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The MODERN HOSPITAL

Vol. XXIX

August, 1927

No. 2



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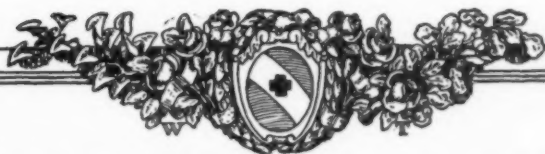
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This Month

Shall the hospital have an open or closed staff?

The advantages and disadvantages of both types of hospitals are weighed and measured by Dr. Ernst P. Boas. Page 49.

Dr. Willard C. Rappleye tells what the community demands of the practicing physician and indicates a goal for medical education. Page 55.

How to plan a small hospital on economical lines is illustrated by the description of the new Westerly Hospital. The article is by Dr. S. S. Goldwater and Warren C. Hill, and appears on page 59.

Lulu Graves tells some ways in which the hospital can lighten the dietitian's work and give her needed support. Page 81.

Miss Gladwin shows that the present educational system for nurses is unsound and suggests ways in which it might be made to reach a higher standard.

In the reading course Dr. C. W. Munger tells how to compute a budget for a hospital. Page 93.

Next Month

How to plan a modern tuberculosis sanatorium will be told in an interesting article by T. B. Kidner, who will describe a sanatorium now in course of construction at Passaic County, N. J.

Establishing the right relationship between the superintendent and the board of trustees will be discussed by Mr. Neergaard, from the viewpoint of the superintendent and that of the trustee. Ways for the superintendent to put himself on a sound basis with his trustee will be indicated and how the trustee can get the best from the superintendent.

How to increase hospital collections is the subject of a practical article by J. J. Weber, which will appear in the September issue.

Dr. Joseph B. DeLee will again discuss the isolation of the maternity department of a hospital and will defend his well known views on this subject expressed in two previous articles, which evoked some criticism from prominent hospital executives who hold opposite opinions.

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXIX

August 1927

No. 2

DOES THE OPEN OR CLOSED HOSPITAL BEST FOSTER THE HOSPITAL'S MISSION?*

By Ernst P. Boas, M.D., Medical Director, Montefiore Hospital for Chronic Diseases,
New York

THE functions and obligations of a hospital are manifold and the determination of any particular hospital policy must therefore be based on a comprehensive study of the many aspects of hospital work.

The primary obligation of a hospital is to its individual patients, who enter the institution with the confidence that all known resources of value in combating disease will be available to them in their effort to regain health. The hospital's duty is not ended by providing bed and board and the various technical appliances that may be necessary for treatment. In admitting the patient it has assumed responsibility for directing and coordinating all of its facilities to meet the needs of the sick person. To this extent the conscious directing force of the hospital must stand above the physician, as it does above the nurse, and must see to it that the physician brings to the patient the best that the present state of medicine can offer.

The second great duty of the hospital is to the community at large. It must take the lead as an educational center for the laity, for physicians, medical students, nurses, dietitians and various types of technical assistants. It should take an active part in moulding public opinion along the lines of public health. It must study the community health needs with a view of directing its own activities into the most needed channels.

The third great function of the hospital is the prosecution of medical research. This has not

alone its self-evident intrinsic value; it is also an important factor in elevating the morale of the institution and is a well-nigh indispensable adjunct in the education of the physicians of the hospital staff. The prosecution of research, however, presupposes a satisfactory and successful fulfillment of the other two functions that have already been mentioned.

Problem Is Many-Sided

In discussing the respective merits of closed and open hospitals, we must consider the matter from these several points of view, and endeavor to determine how one or another system will aid the hospital in fulfilling its obligations to the greatest advantage of all concerned. It is a mistake to view this problem from the point of view of the doctor alone. Too many physicians believe that they have a proprietary right to hospital appointments without recognizing the fact that they have obligations to the institution as well. The physician is but one unit, although an important unit, of the hospital.

In this discussion I shall leave out of all consideration the hospital-hotel or private sanatorium, which is conducted primarily for profit and which offers to the patient bed and board and to the physician certain technical facilities in the treatment of his patient. Such institutions often serve a useful purpose, but they are rarely hospitals in the sense that they have a realization of those wider obligations that we have just named. There must be a moving force in every

*Read before the Bronx County Medical Society, May 24, 1927.

institution and this is usually the expression of the individuality of one responsible person, whether he be a physician, a superintendent or a member of the board of trustees.

The open hospital, of course, already exists in many communities and has proved its usefulness and justified its existence. The great danger to such an institution lies in the possibility of its degeneration into a mere hospital-hotel without definite aims or high ideals.

Without a close control on the part of the institution, it is impossible, in my opinion, to give the best hospital service to patients under conditions that allow every physician in the community to treat his private patients, whether rich or poor, in the hospital. Such a condition is analogous to that obtaining in the private pavilions of many New York hospitals. In a well organized, closed hospital all of the facilities of the institution are placed at the command of the physician in charge of the case. He can have as many consultations with competent specialists as he may need and he may invoke all of the technical and laboratory aids in making his diagnosis. This allows of an intelligent and disinterested group study of the patient by means of which expert opinions of specialists are correlated and applied under the direction of the physician in charge of the particular patient. This state of affairs has been brought about not only because these special consultations and examinations involve no extra expense to the patient, but also because the hospital itself assumes the responsibility for the professional care of its ward patients and exacts of its visiting staff the highest standards of care. I think that all will concede that the development of this point of view has been a helpful one and of inestimable benefit to the patients.

One Difficulty in Open Hospitals

A great difficulty with many open hospitals is that the patient is regarded as the private property of the physician who has had him admitted. This means that one doctor alone is responsible for the care of the patient, that except in case of the grossest abuse no one has the right to interfere with the handling of the patient and that the hospital assumes but a minimum of the responsibility for his treatment. This is the natural result of the extension of the principles of private practice to the hospital. The doctor is interested in keeping his patients and in obtaining his fee, and regards any infringement of this privilege as an assault upon his prerogatives and upon his income. The service in a public hospital has developed a certain morale and cohesion and certain standards and methods, to which all

of its members conform. This group consciousness and pride in the service, which redounds to the benefit of the patient, is apt to be lacking in the case of the open hospital.

The disadvantages of an open hospital organization which I have briefly sketched, can, to a certain extent at least, be avoided, but they must be acknowledged before they can be overcome. It is important to realize that giving every physician in the community the right to practice in a hospital does not necessarily bring to his patient the full potential value of the hospital. This can be achieved only by a carefully planned staff organization and control.

I do not know just what staff organization would be most satisfactory for an open hospital with a large staff, but I am sure that it would have to go far beyond the minimum standard set by the American College of Surgeons. I have often thought that the only possible scheme would be to have a high-class chief of service, receiving a salary adequate to enable him to devote much time to the institution, whose duty it would be to see all patients, advise with their respective physicians and be the integrating force on the service. At best the solution is a difficult one.

How Standardization Aids

Much of the success of hospital care is the result of standardized methods of treatment and carefully established routine. This applies to medical as well as to surgical cases. It is well known that system and meticulous attention to detail are essential in every operating room; that exact and carefully studied methods of surgical after-care lower the mortality rate. Likewise in many medical conditions, for instance, in patients with heart disease, systematic methods of nursing care and medication redound to the benefit of the patient. Often the whims of the individual doctor must be disregarded for the benefit of the many. With the proper staff organization, of course, all such matters would be settled at staff meetings, but all physicians would then have to agree to abide by these decisions.

With a large and varied staff, teaching, clinical studies and research would become difficult, if not impossible, unless all of the physicians agreed to pool their cases and give up their specific prerogatives for these particular purposes. Even here, however, there would be many difficulties, for a physician cannot teach and cannot carry on clinical research if he has not absolute control of the patient material.

Further difficulties would arise with the designation and classification of men as specialists. I speak from experience when I say that most of

us are prone to call ourselves competent specialists before we are entitled to do so. It is not enough for the hospital to decide that Doctor Smith may have surgical privileges and Doctor Jones obstetrical privileges. The doctors in question might be quite competent to deal with an uncomplicated appendicitis or a simple labor but too inexperienced to perform a gastro-enterostomy or a cesarean section. Who is to determine how much responsibility may be intrusted to the many physicians on the staff of an open hospital? For we must always remember that the hospital should guarantee to its patients the best treatment that medicine has to offer.

Let us for a moment consider the reverse side of the picture—the closed hospital. You are all cognizant of the many advantages of this type of hospital. It has a well knit and well disciplined medical staff. The direction is in the hands of a relatively small group of men, and by a system of apprenticeship the younger generation is educated for positions of greater responsibility. Methods of treatment can be standardized, teaching and clinical research can be well organized. Specialists are men with real training and wide experience.

But in spite of the many virtues and advantages of this system, there are many just causes of criticism. Too often the physicians on the staff of the closed hospital seem to believe that they have a vested right in their appointments and are too apt to regard all outsiders as intruders. At times they do not fulfill their full duty to the hospital, but content themselves with routine visits to the wards, which are of little benefit to the patients or to the institution. Furthermore, in many hospitals too much emphasis is placed on the established hierarchy, too much on the appurtenances of rank and seniority, too little on individual capability and faithfulness in the performance of duties. It seems to me that there always will be a need for closed hospitals but that it is time for them to pause and take stock.

An analogy might be drawn between the popular view of a democratic form of government and the open hospital on the one hand, and an intellectual aristocracy and the ideal closed hospital on the other. It is useless to debate with those who believe that a democracy makes every one equal and gives equal rights and privileges to all in every form of human endeavor, irrespective of individual capability and character. To my mind democracy means equality of opportunity. Preferment should depend upon the way this opportunity is utilized. Similarly, the physician's right to a hospital appointment lies in the opportunity which it gives him for the unfolding of his talents.

If he does not take advantage of the situation, he should make room for another. Furthermore, a physician on the staff of a hospital has no prior claim on promotion to higher rank except in so far as his ability and devotion to duty have prepared him for wider fields of activity.

While the closed hospital must maintain a well knit staff, it must provide opportunities for every physician whom it can possibly absorb into its organization. A large staff of young men and a small staff of older men is probably the best arrangement. Controlled only by the physical limitations of the institution, every young man who applies should be given a chance to work and to learn. He should be given every opportunity and should receive advice and inspiration. In return, he should give much time and conscientious effort in the performance of his duties. Some of these men may be assigned to routine work; others may be granted the opportunity of conducting certain special investigations. Every year the entire staff should be carefully and impartially weighed in the balance. Those who do not measure up to the standards set should be released to make room for others. On being released, these men should harbor no grudges. After all, every man is not built for hospital work. This does not necessarily mean that one man is better than another but rather that they have different fields of interest. A hospital physician in a closed hospital should place his institution and his work there first; it should not be just an incident in his daily life.

Modified System Is Needed

Both open and closed hospitals are needed by the community and by the medical profession, but both must undergo certain modifications and must realize more vividly their wider community responsibilities. I am in whole-hearted agreement with Dr. Goldwater's statement that "the need of a hospital connection for every practicing physician should be the controlling factor in all community hospital organizations." The closed hospital, while not relinquishing its scientific ideals and more formal organizations, should become more liberal and throw open its doors to as many physicians as it can absorb, and by a frequent rotation of members of its staff, should spread its influence more widely through the profession. The open hospital, while offering its facilities to all physicians, must not remain content with being a mere hospital-hotel or sanatorium, but must inject a conscious idealism into its activities. Primarily it must realize that it cannot best serve the patient and the community unless it assumes definite measures of control of the professional activities of its medical staff.

WHY IT IS IMPORTANT TO HAVE A PHYSICAL THERAPY DEPARTMENT

By C. J. Cummings, Superintendent, Tacoma General Hospital,
Tacoma, Wash.

THE hospital represents an important business in any community, similar in many respects to other business institutions, dealing not in the necessities of life but with life itself; not operated for financial gain, but merely seeking the higher reward, that of healing the sick.

The hospital that fulfills this purpose is the one that selects worthy objectives and then strives continuously to attain them. Some objectives applicable to any hospital are:

1. To provide adequate professional care for every patient admitted to the institution.
2. To educate nurses, physicians, dietitians and technicians.
3. To contribute to the education of the public on matters pertaining to public health.

This is a challenging program—one that will increase the hospital's field of usefulness and give it an opportunity for great development. It is a program that requires not only financial support but much thought and conscientious effort. If this hospital business is to yield a dividend,

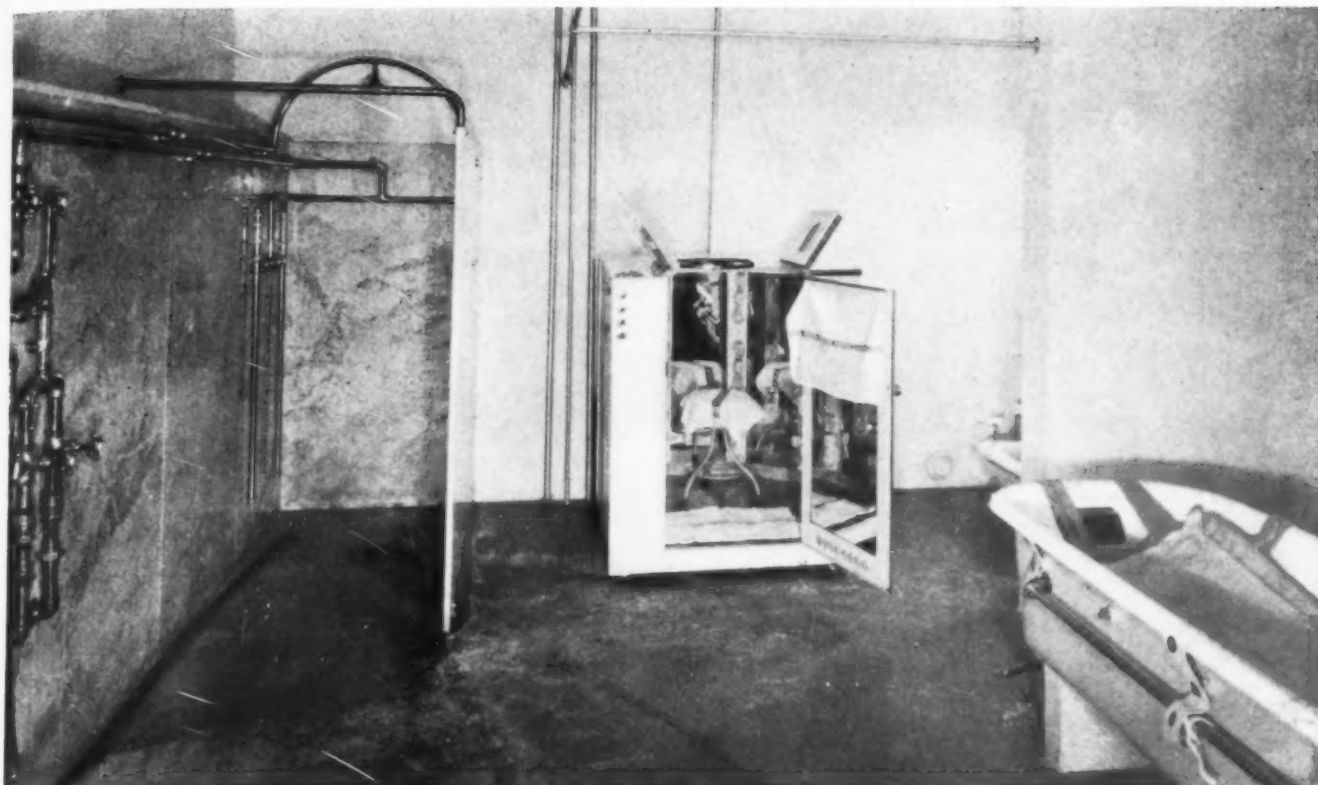
it must have a substantial foundation consisting of suitable buildings, adequate equipment and, above all, a skillful, energetic, conscientious staff, supported by sound business methods. Last but not least the institution should have available, a liberal supply of "preferred stock," consisting of public confidence and good will, which may be called into use at any and all times. This "stock" may be accumulated in liberal quantities by rendering efficient hospital service.

The custom usual in successful business of maintaining a daily balance sheet and systematic inventories taken at regular intervals, in order that a record may be kept of profit and loss, is absolutely necessary, especially in this age of keen competition. The hospital is no exception to this rule; especially is it important that a careful watch be kept on the "service" balance sheet.

A hospital's assets may be listed as follows: an efficient professional staff and personnel; public confidence and good will; satisfied patients; improved patients; patients that are entirely cured.



One of the physical therapy rooms, Tacoma General Hospital, Tacoma, Wash.



Baths and physical therapy equipment used at Tacoma General Hospital

Its liabilities comprise low standards, unskillful professional staff; lack of public confidence and respect; dissatisfied patients; deaths.

It goes without saying that the good hospital is the one that is making a daily, energetic, conscientious effort to increase its assets and decrease its liabilities. This may be accomplished by gradually improving the standards of the institution by improving professional care; by keeping pace with modern progress; by supplying adequate diagnostic and therapeutic facilities, and by education of the public as to the necessity for such things.

Detailed organization of the hospital service in general, and in each department, is essential, in order that the highest degree of efficiency may be attained. The nursing service, surgical service, maternity service, x-ray and pathological departments, laboratory, dietetic service and physical therapy department are necessarily a part of every well governed hospital. Each department is a distinct unit, functioning in the closest cooperation with all other departments and with the hospital as a whole; each has a separate head, with full authority to regulate procedures within his own department.

One of the latest additions to the therapeutic services of the hospital is physical therapy. This branch of medicine includes the treatment of disease by means of physical agencies, namely, electricity, water massage and exercise. It was long

considered a mere fad by a large percentage of the medical profession, but is now recognized almost universally and has been given its proper position alongside of medicine and surgery. This fact was definitely established by the appointment by the American Medical Association of a council on physical therapy. This council is now functioning, to the end that this branch of medicine may become a standardized procedure.

The Tacoma General Hospital, Tacoma, Wash., being desirous of keeping pace with modern progress by supplying adequate diagnostic and therapeutic facilities, in October, 1924, inaugurated a physical therapy service for the benefit of house patients and for such out-patients as might be referred to it by members of the attending staff. The department has been operating continuously and successfully since that time.

The original space and equipment was limited, although adequate to meet the needs. The service has increased in popularity, both from the standpoint of the physician and the patient, and we have found it necessary gradually to expand by providing additional space and equipment. At present the physical therapy department occupies more than 1600 square feet of floor space, is provided with modern electrical and hydrotherapeutic equipment and has a corps of well trained physical therapy assistants, supervised by a physician who gives his full time to this department.

The equipment consists of three high frequency

machines, two air cooled quartz lights, one water cooled quartz light, radiant heat lamps, low voltage machine, whirlpool, sitz and continuous baths, electric cabinet and other accessories.

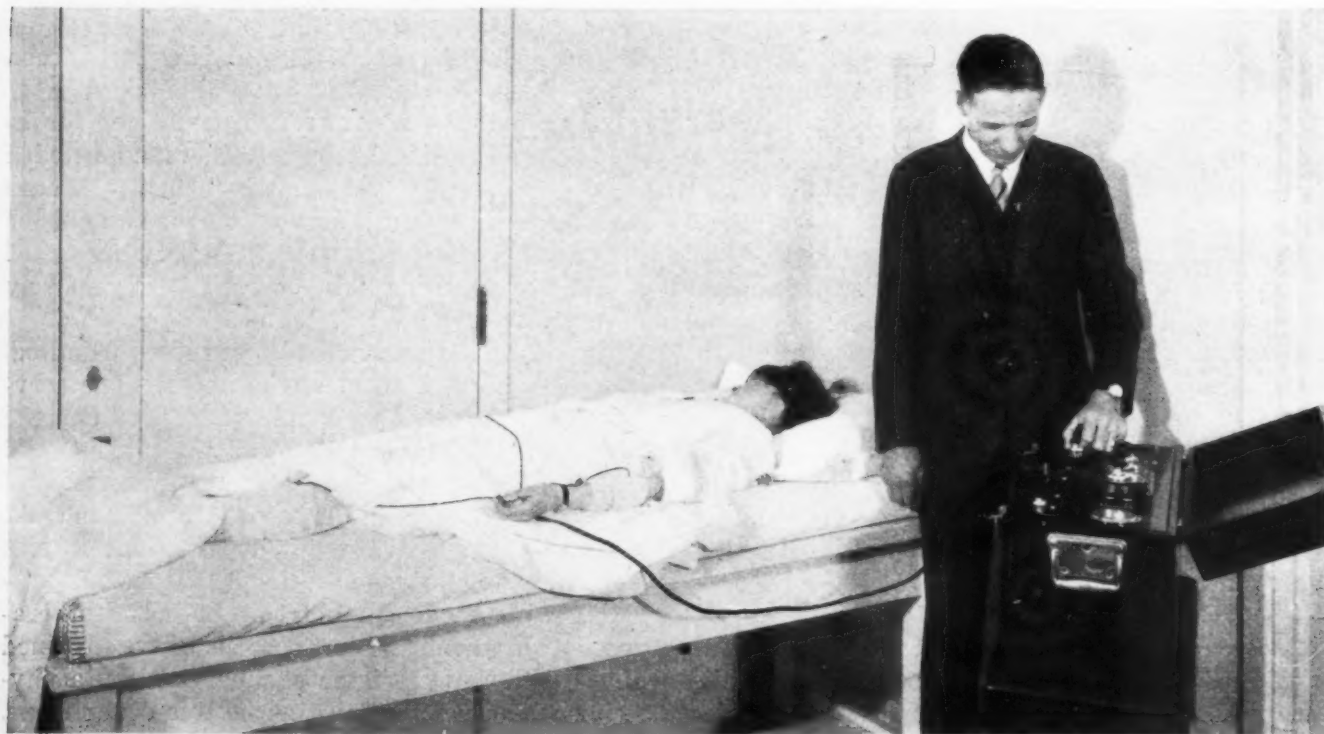
The space allotted to this department is divided into rooms, all connected by double doors in order to allow apparatus to be moved from one room to another easily. The large room, 16 by 36 feet, as shown in the accompanying photograph, contains most of the electrotherapeutic equipment. The adjustable curtains are used to provide cubicles for every patient. There is also a separate room for the electric cabinet, which is also provided with a couch. Adjacent to this is a room with cement floor for the hydrotherapy service. There are two other rooms used for private treatments and an additional room for the office and examining room of the physician-in-chief.

The success of this service depends largely upon the physician, who is qualified by reason of training and experience to prescribe and supervise all treatments properly. Arrangements were made over one year ago for this type of service by employing, on full time status, a physician who has had experience in private practice, and has also spent several years in various government hospitals where physical therapy is employed extensively, under proper medical supervision. Dr. Frank B. Granger, Boston, Mass., stated in an article on "A Hospital Department of Physical Therapy," published in the March 12, 1927, issue of the *Journal of the American Medical Association* that so far as he knew the Tacoma General

Hospital was the first civilian hospital to adopt this policy. If this branch of hospital service is essential, and we believe it is, and if it is to succeed and render efficient service, it should certainly not be carried on without proper organization and medical supervision.

From this department we expect and actually obtain definite therapeutic results. The greater care observed in prescribing and administering the treatments, the better the results. Every patient referred for treatment is given personal attention by the medical director, a separate case record is made, detailing the type and length of treatment. Progress notes describing the results of treatment are included in this record. This we consider valuable not only for the benefit of the patient but as a permanent hospital record.

Remembering our responsibility of educating and training professional personnel, including technicians in laboratory and physical therapy service, we have organized a training service for nurses and others who have an inclination to qualify themselves as physical therapy assistants. The curriculum of the nurses' training school includes some theoretical and practical training for each person in the nurses training school and courses of lectures have been arranged from time to time for the benefit of the attending staff. In September, 1926, Dr. Frank B. Granger gave a series of lectures on physical therapy at this hospital. The course was attended by approximately seventy-five physicians. We plan to arrange for similar courses to be given here in the future.



Patient receiving electrocardiographic treatment

GETTING A PICTURE OF COMMUNITY HEALTH NEEDS*

By Willard C. Rappleye, M. D., Director of Study, Commission on Medical Education,
New Haven, Conn.

LAST year at the Hartford, Conn., meeting of the New England Hospital Association I had the opportunity of telling briefly the history and plan of the Commission on Medical Education. I am glad this year to report to you the progress we are making, and more particularly to discuss some of the general problems with which our study is coming in close contact.

We have gone on the assumption that medical education concerns itself primarily with the qualifications and preparation of students for the practice of medicine, and that the basic course should also be a foundation for those who desire to go into one of the specialties later, into research, public health work or medical education. Furthermore, the basic course should serve as the groundwork for the continuing self-education which is so essential for the physician if

he is to meet in any satisfactory degree his responsibilities in medical practice.

Our first effort was to secure data that would throw light on the needs for medical service of various kinds in different communities. This we secured by a study of the actual health needs of individuals as determined by the results of the draftboard examinations, from data assembled by insurance companies, the Life Extension Institute, the examination of a large number of school children, the examination of industrial employees and from other sources of this character. The material so assembled gives a fairly clear picture of the actual health needs, regardless of whether those needs are being met.

In addition we secured data of the daily practice of over five hundred recent graduates who are

doing general practice in communities of 50,000 population or less, in twenty-six states and provinces. This gives us a good picture of the demands that are actually being made for medical service, and an analysis of 20,000 patient-visits showed that approximately 55 per cent of these visits were in the physicians' offices, about 35

per cent in the patients' homes and about 10 per cent in hospitals. Further study of the data reported showed that about 75 per cent of the office visits were for minor surgery, upper respiratory infections, general medical and venereal diseases; 90 per cent of the home visits were due to respiratory infections, general medical and contagious diseases, obstetrics and minor surgery. In the hospitals about 55 per cent of the patients were surgical, 30 per cent medical and 15 per cent obstetrical.

Our idea in securing the distribution of needs and demands for medical service was not made with any thought that the basic course in medicine should be designed only in relation to these needs, for it is quite evident that many of the important problems are in the small minority of other complaints, and many of the essential problems of medical practice cannot be indicated by such statistical studies. We felt, however, that a picture of the actual demands of practice should be kept in mind. Our studies were compared with the records of over 900,000 patients seen under the national health insurance act of Great Britain, and with 5,400,000 out-patient visits in fourteen of the large cities outside of New York State and 256 clinics located in that state. Further comparisons with absenteeism in industries, which correspond, incidentally, with about 80 per cent of the demands being made on the practitioner, and similar comparisons were made.

The Central Unit

EVERY indication points to a much increased responsibility of hospitals, not only in the cities but in the smaller communities, in the program of medical service. Through the necessary cooperation of practicing physicians with nurses, social workers, hospital administrators, lay boards and the public, the physician must in the future have a clearer conception of his function as a professional worker with a large community responsibility. As time goes on the physician must more and more assume obligations in the guidance of community policies in relation to health matters, and it is quite evident that the trend is toward making the hospital the central unit in preventive medicine.

*Read at the meeting of the New England Hospital Association, Boston, May, 1927.

The study points rather clearly to the fact that over 90 per cent of the demands for medical service are the demands of individual patients, and are due to illnesses that cannot be controlled primarily by community or wholesale methods. It emphasizes particularly the individualized and personal character of most medical service.

The commission has also made further studies on the distribution of physicians. So much has been written and said about this question that everyone familiar with the problem is aware of the fact that the economic and social factors probably control the situation, and that much of the practice of small communities, at least in those near the large cities, is now being done by physicians located in the cities.

The telephone, the automobile and good roads have greatly extended the radius of practice, and increased use of hospitals has tended to centralize practice in larger communities. There has also been a great increase in the amount of office as well as hospital practice, which in turn has considerably reduced the proportion of "domiciliary visitation" in practice. The trend toward centers of practice is, of course, removing local resident medical service from small and rural communities and to some extent is removing adequate medical service from those living in such communities who are unable or unwilling to pay for such services from a distance, or who are unable to go to the medical center. Adequate transportation facilities are correcting some of the inevitable ill effects of centralized practice, however. The extension of modern hospital facilities into smaller communities is rather rapidly decentralizing the centers of practice also, and in a short time some of the large problems of small community practice will be solved.

Specialists on the Increase

There are certain trends in medical practice that have considerable significance in relation to the ways and means by which medical services are to be made available to the population and to individuals. A study on specialization, made partly through our organization, showed that about 40 per cent of recent graduates limit their practice to a specialty, and that close to one-half of those who do limit their practice to a specialty do so without a previous experience in general practice.

It is quite apparent that because of the enormous growth in the knowledge of the causes and treatment of disease and the increasing technical skill required in treatment of many of them, specialization to a certain degree is inevitable. It is obviously impossible for an individual to master all branches of medical science and practice, and a

division of labor can be the only answer. Specialization has been developed in certain sections of the country, at any rate, with a commercial flavor. Many of the recent graduates are going into the specialties because the economic return is easier, and certainly it is far more convenient to practice a specialty than it is to do general work. Moreover, the public has been educated to seek specialists.

The trend toward over-specialization in medicine is probably one of the outstanding current problems and this is particularly true in the concentration of specialists in the large cities where at the present time about 25 per cent of the doctors limit their practice to a single specialty. This compares with 2 per cent to 3 per cent who limit their practice in communities of 10,000 or less.

Emphasis Is on Prevention

In any form of division of labor there must necessarily follow a certain coordination of effort, which is represented in the development of hospital and clinic facilities throughout the country. Furthermore, the necessity of highly technical procedures of surgery, metabolism, laboratory determinations, x-ray work and intensive nursing, particularly in the major and serious illnesses, have made it necessary to develop hospitals.

The hospital is also rapidly extending its function beyond the realm of curative medicine into the field of preventive medicine. Probably the next greatest change in medical teaching and in medical service will be in the emphasis on prevention. Much of prevention in medicine is dependent upon early diagnosis and treatment. The hospital, as the community center for technical services and personnel, is sure to become and in many instances has already become the key in the program of preventive medicine, particularly as it relates to the non-communicable and non-community types of illness which, as mentioned earlier, represent such a large fraction of medical needs.

The organized public health efforts will continue to control environmental diseases and will continue their efforts and activities in public education regarding many of the social, economic, industrial and other factors that have a bearing on disease; and hospitals and clinics, with their individualized, personal application of medical science, will become the key in any form of combined curative and preventive medicine. This probably is going to be especially emphasized in the out-patient and clinic services that are coming to be more generally established in conjunction with general hospitals.

Practically all medical students before they are

licensed to practice medicine complete an internship in a hospital. These students have become accustomed to and dependent upon hospital diagnostic, nursing and other facilities and are reluctant to practice medicine where such facilities are not available. In our study of the demands for medical practice we asked the question, "Is your community adequately provided with hospital facilities?" and the following responses were received:

Hospital Facilities	Considered Adequate
Surgical	72 per cent
Medical	69 per cent
Maternity	63 per cent
Chronic and convalescent.....	44 per cent
Tuberculosis	37 per cent
Incipient nervous disorders.....	32 per cent
Contagious diseases	26 per cent

It is well known that in many communities there is a lack of hospital facilities and there is considerable belief that the distribution of physicians in the future will to a large extent follow in the wake of the distribution of hospitals. There are certain qualifications necessary in thinking of the extent to which hospitals may be distributed, but every community of reasonable size ought to have available its own unit of hospital service. And by hospital service is not meant alone a hotel for sick people, with even a modern operating room attached thereto, but a hospital in the sense of a diagnostic, therapeutic, professional unit service as the center of medical practice, preventive medicine and health activities.

How Best to Use Physicians' Time

The probable increase in the ratio of population per physician during the next twenty years, and the increasing utilization of medical services for early diagnosis and treatment, for the treatment of minor complaints, for periodic medical examinations, for infant and child guidance, as well as the widening of medical services in psychiatry, industry and schools, point to the importance of securing the maximum effective use of the physicians' time. While there are many features that promise to increase certain demands in practice, there are others that have reduced and will further reduce the demand, particularly the control of typhoid fever, malaria, hookworm, diphtheria and other communicable and environmental diseases.

We have been attempting to bring together information about other conditions of practice involving specialization; the various methods of co-operative practice; the increasing degree of hospitalization and office practice; the shift in the duties of the general practitioner to those more es-

entially of internal medicine and pediatrics as the base of medical practice; the growth of preventive medicine in the form of periodic medical examinations; the growing intimacy of public health work, the activities of voluntary health agencies and of medical practice; the extension of various forms of industrial, school and group medicine; the growing use of non-medical assistants in laboratories; home nursing and other fields.

This has been done largely to bring back into the basic course some definition of the larger ramifications of medical practice in the community. This, it is hoped, will give the medical student and prospective practitioner of medicine a great deal more insight into the type of responsibility and the type of contact that he is likely to have in medical practice. At the same time it should bring to him a realization of the larger opportunities that he, as a trained technical practitioner of medicine, may have in the shaping of public opinion and in the guidance of sound health work in the community in which he will practice.

Providing for Middle-Class Patients

Let me digress one moment to touch upon the question of providing medical services for the large proportion of the population of moderate means. At the present time there is active discussion not only among medical and hospital groups, but among politicians, economists, industrial leaders and others on this question of providing adequate medical service at a cost that can be met by the average individual of moderate means.

It is quite evident that the great increase in the cost of modern medical services is due almost entirely to the enormous expansion of what we consider to be adequate medical service. This is represented largely in the development of hospitalization, which in its very nature must be expensive, and in the great expansion of laboratory, x-ray and other technical services of this character, as well as the high degree of specialization, which it is alleged is necessary to render proper service. A number of hospitals are now being built and present institutions are being fitted out to make special provision for this particular group of the public to whom serious illness, surgical operations or a period in the hospital even for diagnosis may be so expensive as to disrupt completely the economic stability of their homes and present to such families a rather serious financial crisis. The suggestion of medical and hospital insurance is again heard. A large number of industries are already working on this plan, particularly for ambulatory patients, and we shall probably see in the next decade a considerable change in methods

of financing certain phases of our hospital, clinic and medical practice.

The chief function of the Commission on Medical Education, of course, is in connection with the training of students so that they may be competent to begin the practice of medicine. We have not been approaching the question so much from the standpoint of the details of curriculum or of pre-medical requirements or of state licensing board regulations, but have thus far been concerned chiefly in getting, as clearly as possible, a visualization of the needs and opportunities of medical practice of the future.

Every indication points to a much increased responsibility of hospitals not only in the cities but in the smaller communities in this program of medical service. Through the necessary cooperation of practicing physicians with nurses, social workers, hospital administrators, lay boards and the public, the physician must in the future have a clearer conception of his function as a professional worker with a large community responsibility. As time goes on the physician must more and more assume obligations in the guidance of community policies in relation to health matters, and it is quite evident that this trend at the moment is toward increasing the importance and the opportunity of the hospital as the organized central unit in preventive as well as curative medicine. It is this importance of coordinated and cooperative medical practice in hospital and clinic units that we are trying to formulate and emphasize in the basic training of the physician.

COMMITTEE ON DISPENSARY DEVELOPMENT TERMINATES ITS WORK

In a recently issued report the United Hospital Fund of New York announces the disbanding of its committee on dispensary development, at the termination of six years' work, spent in studying and endeavoring to improve the clinics of New York City, both in and out of hospitals.

The committee's activities were carried on with funds provided by The Rockefeller Foundation. Henry J. Fisher was chairman of the committee and Michael M. Davis, executive secretary.

The report shows that a million and a quarter persons now receive care in the out-patient departments of hospitals in New York City and in clinics and health centers unattached to hospitals. Thirty years ago most clinics merely doled out medicines and hasty medical advice to the destitute sick. Now service is given in all the specialties of medicine and surgery, aided by the laboratory, the x-ray and other modern equipment, and associated with more and more preventive work designed to forestall sickness.

The number of patients in the clinics of the city, as a whole, has increased about 20 per cent during the past six years, and the improvement in the quantity and quality of out-patient service and the facilities for it

have been reflected in an increase of 49 per cent in the expenditures of the clinics as compared with six years ago. In 1920 the expenditures for out-patient work were \$1,598,372, while now they are approximately \$2,379,000 a year. Progress in almost every phase of out-patient work is indicated in the report. At present 2,500 physicians and 3,000 other workers man the clinics.

In spite of the advances along many lines the report points out that "conditions are still far below what they should be. Examination of patients in many clinics continues to be hasty and superficial because of limited space and overburdened doctors. Antiquated record systems, in which the institution's record of patient's condition is split into as many comparatively inaccessible parts as there are specialties that have treated the patient, are still maintained because of inertia, lack of appreciation of accepted standards or fear of expense. Money and effort are wasted because treatment is started on patients without a systematic attempt being made to carry it through to completion."

Responsibility for these conditions is attributed to boards of trustees in privately supported institutions and to members of senior medical boards.

Among the chief recommendations of the committee, based on its six years' work are the following:

More pay clinics like the Cornell Clinic, which treats persons of moderate means at cost. Such pay clinics should give adequate remuneration to their physicians.

Extension of preventive service through periodic health examinations.

Further improvement in the standards of service in clinics generally.

The establishment of additional clinics in the Borough of Queens, and in certain districts of Brooklyn, where the population is increasing rapidly.

More clinics in certain specialties such as dentistry, prenatal work and mental hygiene.

The promotion of district health centers, coordinating for a given area clinics now scattered or overlapping in service.

Better teamwork between clinics and charitable agencies to prevent existing waste of effort and money.

Revision of the state dispensary law.

Continued research in order that the clinics may keep pace with growing needs and changing conditions and thus be able to give fuller service to the community.

WHY THE HOSPITAL IS THE BEST HEALTH CENTER

In order to illustrate the strategic importance of a large general hospital as the best health center, the advantages and disadvantages of other medical agencies that now also serve as centers may be reviewed, says *Hospital Social Service*. One of these is the dispensary. By this we do not mean an out-patient department of a hospital, but an ambulatory clinic not organically connected with any hospital.

While the dispensaries, especially if connected with teaching institutions, may give splendid service in the care of patients not requiring hospitalization, yet since their responsibilities for the patients are so seldom brought to the testing point, and since they have such difficulty in following and controlling their patients, their staffs seldom develop the professional quality of hospitals or hospital out-patient departments, and tend to superficial routine work.



A FIFTY-BED HOSPITAL PLANNED ON ECONOMICAL LINES

By Warren C. Hill, A.I.A., Kendall, Taylor & Co., Architects, Boston, and S. S. Goldwater, M.D., Consultant, New York

THE complexity of hospital work as fully developed in institutions of large size, frequently depresses those who are faced with the need of providing ideal hospital accommodations for a small community. Hospital architects must, however, frequently answer the question whether it is possible to plan a fifty-bed hospital unit on economical lines.

Granting that the fully developed 500-bed hospital, which only large communities can afford, will be better able to perform more thorough diagnostic and therapeutic work than can ordinarily be accomplished in a modest hospital of fifty beds, the fact remains that small and isolated communities do not need and cannot support a large, general hospital and must content themselves with hospitals of smaller size. Indeed, it is well known that a majority of the hospitals of the country are small hospitals, and an ever present problem, therefore, for those who are engaged in hospital planning, is the arrangement of small hospitals in such a manner as to facilitate economical and efficient service.

The program of the Westerly Hospital, Westerly, R. I., called for approximately fifty patients' beds. Within this small number it was necessary to include private, semi-private and ward patients; separate accommodations were desired for maternity cases and for children. It was agreed that a nurses' home would be provided apart from the main hospital building, and that local conditions called for the provision of accommodations for a considerable proportion of the domestic help.

For the purposes of the hospital, attractive

land comprising several acres was donated by Charles Perry, president of the hospital association. The Sarah Alexander Champion Home for Nurses is a separate three-story and basement structure of domestic type. The main hospital building is of brick and concrete, with granite trimming. The nurses' home is of stucco. The hospital is a fireproof building, while the nurses' home is nearly so.

The main axis of the hospital building extends from north to south. The building consists of a ground floor and two upper stories. On the two upper stories accommodations are provided for fifty patients of all classes. The male ward and the children's ward occupy the first floor, together with separation rooms for children and a limited number of separation rooms for male ward patients. A part of the first floor is reserved for a public reception room, the business offices of the hospital, suites of rooms for the superintendent, for physicians and interns and the clinical laboratory. On the second floor are the women's ward, maternity ward, private rooms, operating rooms and delivery rooms.

It is assumed that the hospital will grow, and the plan lends itself to the erection of additions at both extremities of the main portion of the building, in addition to which the rear wing, containing the kitchen on the ground floor, children's wards on the first floor, and operating rooms on the second floor, can readily be extended proportionately.

In earlier studies the merits of a three-story building and a two-story building were compared,

and the conclusion was reached that administration would be more economical and satisfactory if all of the fifty patients could be controlled from two rather than three nurses' stations. The plans show an almost equal distribution of patients, twenty-four being accommodated on the ground floor and twenty-six on the second floor; these numbers, however, are not definite, since certain rooms designed primarily as single rooms can, if necessary, be converted into double rooms.

It is the hope of the designers of this building that the solariums will be permanently retained for the purpose for which they were planned, but it must be reluctantly confessed that many hospitals of this type appropriate solariums for ward purposes just as soon as the hospital begins to experience pressure. If Westerly should follow this unwise example, the fifty-bed hospital, which is the subject of this article, might easily be converted into a sixty-five or seventy-bed hospital, without new construction; in that case the solariums would become sun wards for the permanent occupancy of bedridden patients, instead of an invigorating means of recreation and enjoyment for convalescents.

To house the component parts properly the area of the ground floor of the building is somewhat greater than that of the first floor, and a broad terrace is thus created across which the main entrance to the hospital is approached. The reception room is designed and furnished in an attractive manner, and is flanked by a private waiting room on one side and by three communicating business offices on the other. In the immediate vicinity of the business offices are the laboratory, staff room and interns' room. The superintendent's suite is close by. Many of the visitors to the hospital will make use of the outer reception room; others will pass into the ward sections beyond.

Nurses' Station Is Centrally Placed

The nurses' control station for the first floor is directly opposite the reception room door, which likewise faces the passenger elevator. The first room adjoining the passenger elevator is a room for the examination of patients seeking hospital admission.

The east wing of the first floor is occupied by the children's ward, which is subdivided into an eight-bed ward (this is again subdivided into individual cubicles), a connecting solarium, and three separation rooms. The children's ward has its own utility room, toilet, bath and nurses' station, as children need constant watching and much service.

Two single rooms occupy middle ground be-

tween the children's ward and the male ward on this floor; the location of these rooms is such that they may be used interchangeably for children or for adult patients. The floor diet kitchen or serving room located at the meeting point of the two corridors, with both of which it connects, serves both children's and adult wards.

The adult section of the first floor occupying the southerly extremity of the main wing of the building, includes a large solarium, a six-bed ward (this ward, without crowding, can accommodate an additional patient's bed, if necessary), two two-bed rooms and three private or separation rooms. A utility or sink room is conveniently located, and the ward has its own toilet, bath, linen room and cleaners' closet. Running water is provided in all of the single rooms and the wards.

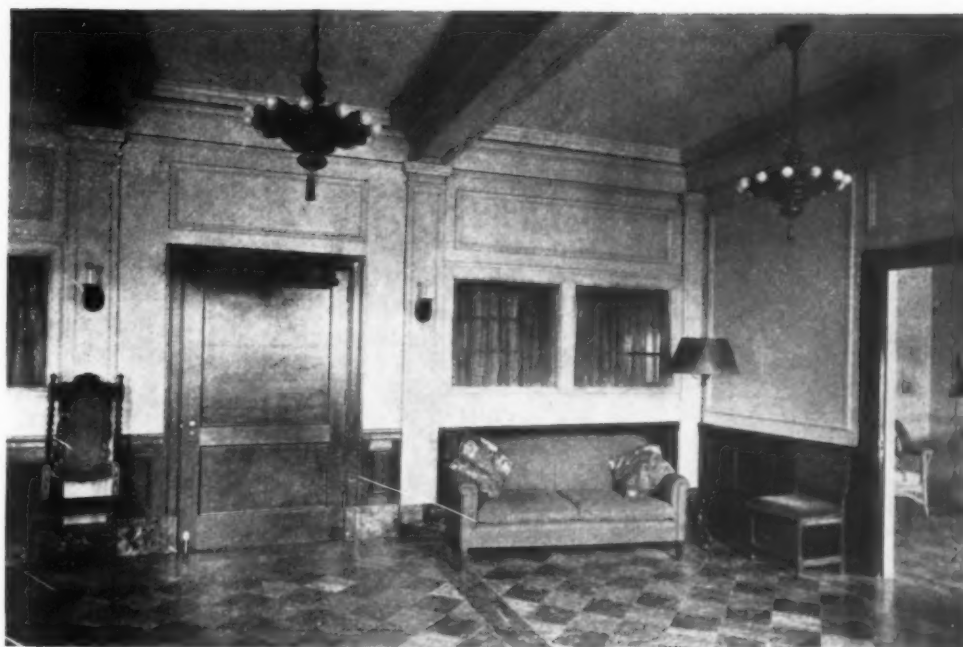
Features of First Floor

The outstanding features of this floor are: (1) separation of adult patients and children, a separation that is not always observed in hospitals of small size; (2) single rooms and two-bed wards of ample number, to provide for any desired clinical classification; (3) the location of the smaller rooms midway between the larger wards, which permits of the expansion or contraction of the two distinct types of ward service, according to need; (4) separate solariums for adult patients and children; (5) the exposure of the solariums south, east and west; (6) the location of utility rooms convenient to ward services; (7) the central location and commodious size of the diet kitchen; (8) the central location of the nurses' station; (9) the utilization of the nurses' station for the control of visitors entering the hospital; (10) the subdivision of the children's ward into a four-bed ward, four individual cubicles, three completely isolated separation rooms and a solarium; (11) direct observation of the several children's ward sections from the nurses' station.

On the second floor, the main portion of the building is used for the accommodation of patients, the rear extension for operating rooms. One end of the main wing provides accommodations for the maternity service. At the other extremity of this wing is the women's ward. In the intermediate section are private and semi-private rooms.

The isolated maternity service includes a maternity ward of six beds, (this ward has five windows on two sides, and a ventilated corridor adjoining) and five private rooms. The birth room and labor room are entered through a private vestibule or passage for sound control. The birth room, with its connecting sterilizing and utility room, is a complete self-contained unit.

*The reception room,
which is furnished in
a homelike manner*



*One of the private
rooms, having running
water and a built-in
closet*

There are eight private rooms with connecting baths and toilets.

Smaller and less expensive private rooms and semi-private rooms are on the opposite side of the corridor. Running water and built-in closets are provided for all private rooms, and there are lavatories as well, in each ward.

The women's public ward contains six beds. Adjoining is a large solarium, as on the floor below.

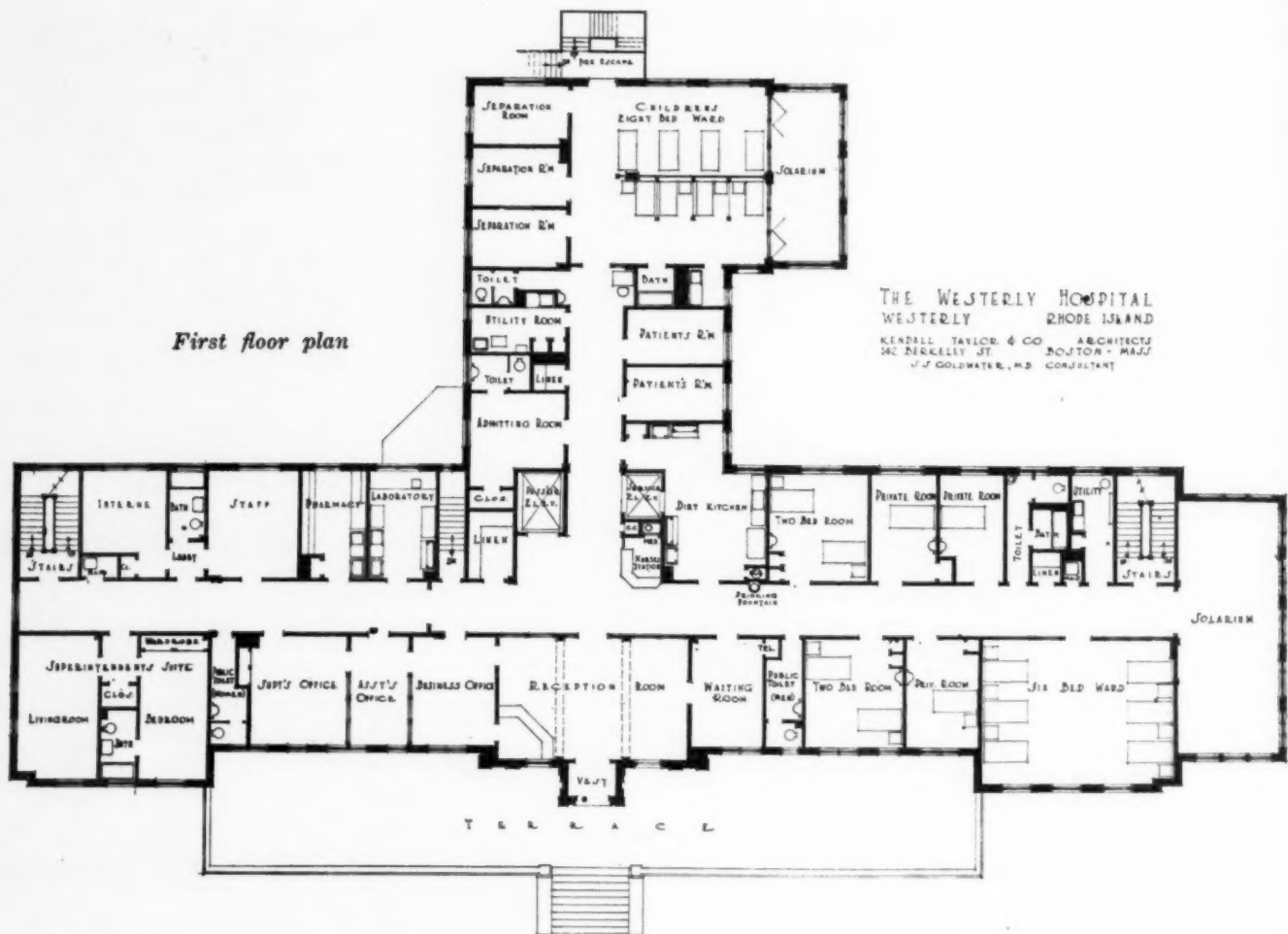
Separate utility rooms are provided for the maternity wards and women's wards, thus reducing to negligible proportions all bedpan traffic in the corridors. The maternity ward and general women's ward have their own baths and toilets. Linen supply closets are placed in accessible loca-

tions at both ends of the building. A single diet kitchen, centrally located, serves the entire floor; communication between the diet kitchen and the main kitchen below is supplied by a service elevator of commodious size.

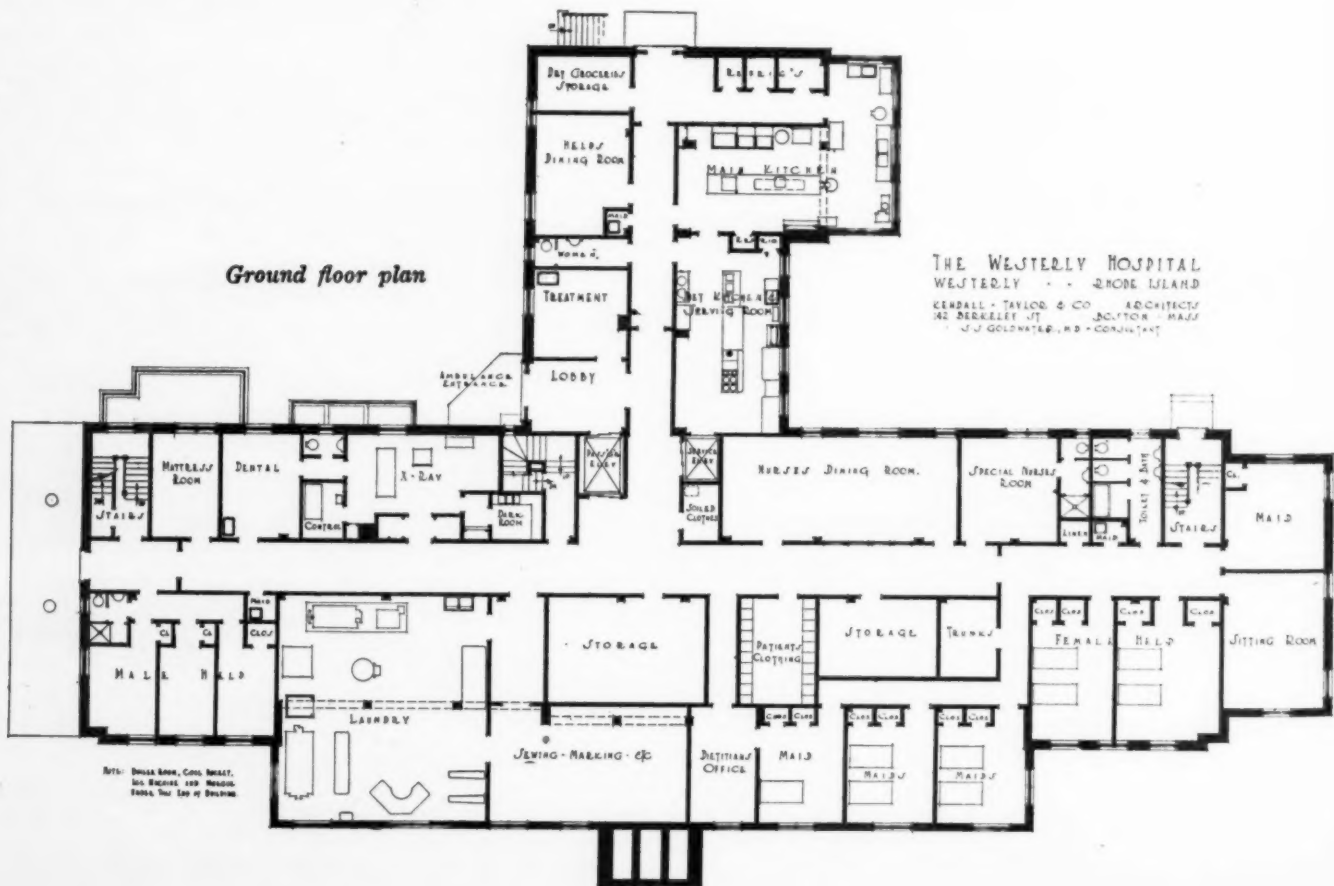
The nursery, with babies' bath and washroom adjoining, opens through a vestibule into the rear corridor. The nursery may be observed by visitors from the corridor through a large fixed sash. The nurses' station is centrally and strategically placed, opposite the passenger elevator, as the one in the first floor.

For surgical purposes there are two operating rooms with a connecting sterilizing room. Additional facilities include scrub-up sinks in an alcove off the expanded corridor, a commodious work-

First floor plan



Ground floor plan



room for the preparation of supplies, a dressing room for nurses, and a dressing room for the surgeons with connecting toilet and shower.

The principal features of the second floor plan are: separation of the maternity from the general service; flexible character of the centrally located private and semi-private rooms; commodious solarium; arrangement of ward service features; location and arrangement of operating rooms; general arrangement to permit of future expansion in three directions, without disturbing any occupied part of the hospital.

The commanding feature of the ground floor is the kitchen. The service entrance is at the rear, through which supplies pass into the adjoining dry and cold storage spaces. For perishable supplies the route lies directly through the refrigerating room to the preparation room, main kitchen and serving room. The combined diet kitchen and serving room, connecting with the main kitchen at one end, communicates at the other with the service elevator for the floors above, and, on its own level, with the nurses' dining room. Opposite the main kitchen is the help's dining room. Cafeteria service is used here, service being at a Dutch type of door at the kitchen.

The ambulance entrance opens into a lobby, on one side of which is an emergency treatment room, and on the other the passenger elevator by means of which patients can be taken directly to the admitting room or to the wards on the first floor, or to wards, private rooms or operating rooms on the second floor.

X-Ray Room on Ground Floor

After providing the required number of beds on the first floor and arranging for office accommodations, superintendent's quarters, interns' rooms and laboratory, no space remained over for an x-ray room or a dental room, which were included in the program. Space for these departments was therefore set aside on the ground floor. The remaining features of the ground floor are: The pharmacy, quarters for male help (consisting of three rooms with connecting shower and toilet), laundry, sewing room, general storage room, dietitian's office, ward patients' clothing room, and accommodations for ten female servants with connecting bath, toilet and sitting room. A locker and dressing room, with shower and toilet adjoining, are provided on this floor for the use of non-resident special nurses.

The special features of this floor are: The compact, easily supervised, and easily managed kitchen, with direct vertical connection to service rooms above, and close horizontal connection with the nurses' and help's dining rooms; level ground

entrances for supplies and for ambulance cases; the expansion of the area of the floor in order to provide adequate space for laundry, help's dormitories and other services; sitting room for the female help; the compact nature of the plan as a whole.

Only a small portion of the basement is excavated, chiefly for the purpose of providing for the boiler room and refrigerating machinery. It was deemed advisable also to place on this level the autopsy room with columbarium, which is accessible from the central elevator.

Ten Two-Bed Rooms

Some months subsequent to the opening of the hospital it was deemed expedient to convert four of the private rooms into additional two-bed rooms, making a total of this classification of ten rooms.

The cost of the hospital without furnishings was \$367,590 and of the nurses' home \$93,211.

The mechanical equipment is of the best and represents an investment for permanency, durability and future growth.

The heating plant is composed of two large sectional boilers, either one of which is ample to care for both buildings. The home is connected by conduit with the hospital. One boiler is operated with an oil heater; the other is for bituminous coal. All radiation is direct and the vacuum system is used. Exhaust fans were provided for the various groups of rooms, that is, the kitchen and diet kitchens are on one fan, the laundry on another, the operating group and the toilets and workroom in each end of the longer patients' section of the building. The fans for each group are separately controlled from the office or from a remote point, with lighting devices to indicate whether or not the fans are operating.

A separate upright boiler for high pressure steam cares for sterilizing, heating water, laundry and cooking. An eighty foot radial brick boiler chimney is included in the costs.

Electric energy is purchased from a local public service company. There are some electric instrument sterilizers, but no electric cooking is done. This is accomplished by gas or steam and all of this equipment is of the most modern character.

Mechanical refrigeration is used in all of the cooling boxes and refrigerators, as well as for a two-cadaver cooling box in the basement mortuary.

A large amount of tiling is used on walls and floors in the operating room, food preparation and serving rooms. Linoleums are used in the corridors and patients' rooms, and rubber tiling in the public rooms.

PSYCHOLOGICAL FACTORS THAT GUIDE THE SUCCESSFUL ADMINISTRATOR

By Ralph B. Spence, Instructor in Educational Psychology, Teachers' College, Columbia University, New York

IF YOU were to set out to improve the efficiency of your hospital organization, which employee would you suggest as the one on which first to fix attention?

Nine times out of ten when such a question is asked a person in an administrative position, he tries to think whether the engineer, the office manager, the kitchen help or the telephone operator, is most in need of immediate improvement. Seldom does it occur to him that probably the most fruitful place to begin operations is with himself. This is quite natural. People are not inclined to look for trouble within themselves when there are others around upon whom can be laid the blame for inefficiency.

When work begins to press on the administrator the employees often find themselves reprimanded for insignificant actions that are perfectly harmless and that have hitherto passed unnoticed. If an important engagement has been overlooked, it was the secretary's fault—she should have reminded him. It doesn't make any difference if she never heard anything about it before. This is a crude example of a type of thing that extends in much more subtle form into all our relationships. Sometimes it is so subtle that we are unaware of it until it is pointed out to us.

Some administrators will at once begin to pat themselves on the back and say, "This isn't meant for me. I am sympathetic and helpful. I am always trying to do the best thing for all my employees."

This may be true without necessarily promoting efficient organization. It requires a careful checking-up on oneself to determine whether one is really doing the best thing in an effective way. The desire to do good, while necessary, is not sufficient to make one effective.

How to Be a Good Executive

What are the characteristics of a person who is a success in managing others? The place to get the best answer to this question is not from the administrators themselves but from the people who have to work with them. Administrators are too much inclined to deal in vague generalities. Employees usually give us specific details. I recently asked a hundred persons to write down the specific acts of administrators they knew that

made these persons a success or the reverse. Here are some of the things noted as being characteristic of a good administrator: he has a pleasant manner; he insists upon fair play by bringing together both parties concerned in a difficulty; he always makes you feel welcome; he knows what he wants; he never criticizes one person before another; after he has told someone to go ahead, he always backs him up.

Characteristics That Defeat Success

Some characteristics of a poor administrator were listed as follows: he wants to take too many details into his own hands; he is autocratic toward subordinates but servile toward superiors; he accuses anyone who disagrees with him of being uncooperative; he systematizes everything to such a degree that employees often do not use the material provided because of the red tape necessary to get it; he fails to keep his hands off after responsibility has been delegated to someone else; he has an attitude of superiority but is unable to back his statements with facts; he neglects important details.

It is never entirely satisfactory to try to make a list of traits to describe any person or group of persons. Words mean such different things to different people. The word "tact" for example means much to some people and little to others. Nevertheless I am going to name a few things that are desirable for the administrator, although the list is in no sense complete and is merely meant to be suggestive. These traits are an adaptation from Charter's list published in the *American Magazine* in 1924.

Perspective. This is an important trait for anyone, no matter what his position in life may be. How often we have been upset over a certain matter and have succeeded in upsetting our organization as well, and, as we look back upon it, it didn't really amount to anything. This ability to see things in their relationship to others, to use the past and the future as the background against which to set the things of the moment, often marks the difference between success and failure. It includes a sense of humor, but it is broader than the usual interpretation of that and so I choose to call it perspective.

Self-confidence. The ability to inspire and to lead comes from a feeling of self-confidence. Don't

mistake for self-confidence the bravado and seeming assurance, often stretching into dogmatism, that some people have. Often this is assumed to cover a feeling of insecurity and inferiority. Employees are not long in finding this out. Real self-confidence doesn't have to be dogmatic.

Adaptability. The ability to change one's plans to meet unforeseen circumstances, while still maintaining enough rigidity so that one's employees are not upset by being continually forced to change their arrangements is a real asset. The necessity of having perspective to guide adaptability is apparent.

Cheerfulness. A cheerful manner is a great help in keeping up the good feeling of an organization. Many administrators are so overcome by the responsibilities of their position that it affects their outward behavior even although they themselves when asked would say that they didn't feel that way. One administrator whom I know brought about a state of strain in his organization because of his worried appearance, yet when this was called to his attention he was much surprised for he didn't really feel that way.

Capacity to delegate work. Many capable people are unable to take charge of others because they are unable to assign tasks to their employees. A person may be able to do many things more efficiently than any of his subordinates, yet if he is ever going to get anything done, he must be willing to be satisfied by some things less perfectly done than he would do them. Some administrators fail to realize that while they can do a task today in less time than they could tell someone else about it, they can't keep up this margin day after day. Such persons are the ones who become swamped with details.

Ability to "size up" people. This is important not only in selecting one's helpers, but also in dealing with them after they have been chosen. It is easy to forget that every person is different. We try to use the same approach on everyone in every situation. A person will be much more successful if he will study the people with whom he works, find out their background and interests and try to adjust his approach to these qualities.

Economy of habits. There are so many things to be done in the daily routine that the advantage is all to the man who can do the tasks he has to do in a quick and easy manner. Reading is an example. Some persons can read three times as rapidly as others and the chances are that they get more out of what they read. People who read slowly usually feel that they read more thoroughly, but experiments show that the advantage is to the rapid reader.

Consistency. Nothing is much sadder than a

person who is continually changing his mind. The ability to change one's mind is an asset when used rightly, but one should not give one decision today, another tomorrow and perhaps come back to the first one next week. I knew one person who told me that she used to start into one department store, then she would come out and start across the street to another store, and about the time she got about half way across the street she would decide that the first one was better after all. Extreme cases like this should have the attention of a psychiatrist, but it is important that anyone who is inclined to do this sort of thing should take steps to remedy it.

Persistence. The record of many great achievements is a record of persistence. The ability to hang on when one is sure one is right is desirable for anyone, but it is essential for a person in an executive capacity because he controls the work of a number of others and his attitude and decisions determine their courses. Persistence in itself may be either good or bad, it has to be linked up with other things. This applies also to many of the other traits here listed.

Effective manner. It may be true that if a man is really good and does his work well, the world will seek him out and make a path to his door, but for an administrator it is more desirable that he have an effective way of presenting his point of view. A pleasant manner of speaking, clearness and brevity in presenting ideas, along with cheerfulness, adaptability and ability to size up people, combine to make a person effective in getting others to understand his point of view, and to understand it in such a way that they will cooperate with him.

Cooperation Is Necessary

As has been pointed out, there is nothing exclusive about this list of traits. There are some successful leaders who are lacking in some of these respects and there are others relatively unsuccessful who may be good in one or two respects. The point to remember is that an increase along any of these lines should help one to attain a greater efficiency in the organization in which one works. Whenever people work together there is a dynamic relationship, an interaction, and since the person in the administrative position is more or less at the center of the group, and touches directly or indirectly a larger number, any change he makes for the better has the possibility of large returns.

The development of the traits listed above is difficult but not impossible. A person's ability to develop any of the ten characteristics is determined partly by his hereditary make-up, but

in practically every case it is possible to make some change. If a man were born with an incurable stomach disorder that doomed him to be a permanent dyspeptic he might find it harder to score high on cheerfulness than a man who thoroughly enjoyed everything he ate, yet everyone knows cases where a person in the most unfortunate circumstances is an incurable optimist.

Neither is age an insuperable handicap. The older a person is the harder it is for him to change in these respects, but recent findings indicate that if he strongly desires to do so, he can effect a change. Thorndike has found that people can learn to do new things up to the age of forty or fifty and in some cases beyond. The older person must simply be willing to work harder to accomplish the desired result.

The thing to be remembered in planning to develop any of the above characteristics is that each one of them is a habit and can be acquired in the same way that any habit is acquired. If a person wants to become cheerful he must arrange situations so that he will have a chance to practice being cheerful, and so that he will feel satisfied when he has been cheerful.

In order to make a really effective attack on the above list of characteristics it is necessary that one have a healthy state of mind. If a person has so failed to adjust himself to his environment that he cannot face reality, he will not get far trying to build up desirable characteristics.

ENGLISH ARCHITECT VIEWS AMERICAN HOSPITALS

A recent issue of the *Lancet* gives some interesting comparisons between American and European hospitals taken from a paper by Lionel Pearson, F.R.I.B.A., read recently before the Royal Institute of British Architects.

The vertical type of construction common in America is contrasted with the horizontal type and the modified pavilion system which still hold their own in Europe. The multi-storied hospital now popular in America, similar to hotel and office buildings, makes possible concentration of services, Mr. Pearson finds, and simplifies the problems of heating, lighting and plumbing. The elevator, laundry chute and other American labor-saving devices are of practical help in the vertical type of building. On the other hand, an important point in favor of horizontal planning is that it makes it easier to handle extensions to the original structure.

The large ward of twenty-five or thirty beds is, Mr. Pearson believes, a thing of the past both in Europe and America. Sixteen-bed wards are fairly common but twelve-bed wards are preferred, while the number of rooms allocated to private and semi-private rooms is constantly increasing, especially in America, where such rooms are a noticeable feature of modern hospital planning.

The sanitary arrangements are fundamentally different in America from those in vogue in Europe. The pipes are almost always buried in the wall or ceiling, which

adds greatly to the smartness and cleanliness of the rooms, and shows confidence in modern methods of plumbing. However, Mr. Pearson views with some misgiving the common American practice of having windowless and mechanically ventilated bathrooms and toilets opening off patients' rooms, and points out the excessive cost and labor entailed by this arrangement. He commends, however, the provision of hot and cold water in private rooms and rooms for nurses and staff.

The central corridor of American hospitals does not, in Mr. Pearson's opinion promote either cheerfulness or health, but he finds much to commend in the attractive entrances and the hotel-type of lounge found in the typical American hospital.

DIRECTOR OF HOSPITAL SERVICES FOR ONTARIO APPOINTED

Dr. Edward Ryan, superintendent, Ontario Hospital, Kingston, Ontario, has been appointed to the post of director of hospital services for the Province of Ontario. This step has been taken by the provincial secretary's department in order that a careful supervision may be kept over the latest developments in the treatment of patients with mental disorders. Dr. Ryan will be responsible to the minister and deputy minister in the discharge of his duties, which will be confined solely to the advancement of the medical field in treating cases of mental illness.

Speaking editorially on this appointment, which is regarded as an important step toward the formation of a commission to investigate hospitals for the insane in the province of Ontario, the *Hospital Medical and Nursing World*, says: "We believe the Government would do well to have a conference of all superintendents of hospitals for mental diseases, inviting thereto superintendents of nursing schools and some of our leading neurologists, legal men and others who are particularly interested in the welfare of the insane and the prevention of insanity.

"Certain points occur to us that might be discussed: Are the hospitals for the insane sufficiently staffed with medical men and have they proper appliances for diagnosis and treatment of the purely psychogenic cases? Are there sufficient laboratories and equipment for performing the needed chemical, bacteriological, serological and radiological investigations of the somatic end of the work? What is being done in the way of pathological study of diseased tissues examined after removal during life and after death? How much postmortem work is being done? Are patients suffering from bodily ailments, medical, surgical, gynecological or of special senses, receiving adequate attention? Are the patients properly nursed? Is it wise to continue training nurses in schools where mental diseases are the main study? How about reciprocating with training schools associated with general hospitals? Further, inquiry might well be made into the question of manual labor, occupational therapy, recreation and classes for mental improvement. We think too, a study might be made of the dietaries of the patients. Beside the above subjects, the investigation committee would find many other subjects of like interest which ought to be discussed.

"We would respectfully suggest that the government press upon their staffs the importance of such a conference or conferences; and that these meetings be held periodically. We fear that if they do not, pressure from the outside will eventually force the government to appoint an outside commission to enquire into conditions which we believe should be remedied."

A GYNECOLOGICAL AND OBSTETRIC BUILDING THAT IS MODERNLY EQUIPPED

By James H. Ritchie and Associates, Architects, and John J. Dowling, M.D., Consultant, Boston

THE gynecological and obstetric building of the Boston City Hospital, Boston, is the first completed unit of several new buildings that the city of Boston proposes to erect for the enlargement of this institution.

The new unit is placed at the northeast corner of the hospital grounds facing two streets, the principal façade being on East Concord Street. The main entrance, which is treated in a simple manner, is within the hospital grounds.

The building has six floors above the basement, with a total length of 150 feet. It contains 126 beds in open wards, twelve beds in isolation rooms and 117 babies' cribs.

The exterior design is an adaptation of the Georgian style of architecture in keeping with the existing buildings of the hospital group. The exterior walls, to the level of the second floor window sills, are faced with stone; all walls above are faced with red water-struck brick with stone trim. The roof is flat, covered with tar and gravel.

The foundations are caisson piles which are placed under all columns, the frame is reinforced concrete, the floor and roof construction is of terracotta tile and concrete joist, one-way system. Ow-

ing to the nature of the soil the exterior walls and floors of the basement are carried on beams.

The two stairs within the building are of reinforced concrete construction, the main stair having terrazzo finish and the stair at the end of the ward having granolithic finish. The balconies are of steel construction, with one-inch rough plate glass floors and wrought iron railings. The fire stair adjoining the balconies is steel, with granolithic treads and landings. It is enclosed with wire plate glass protected by wrought iron grilles. The sun porches are of steel construction, with steel casement sash and granolithic floors.

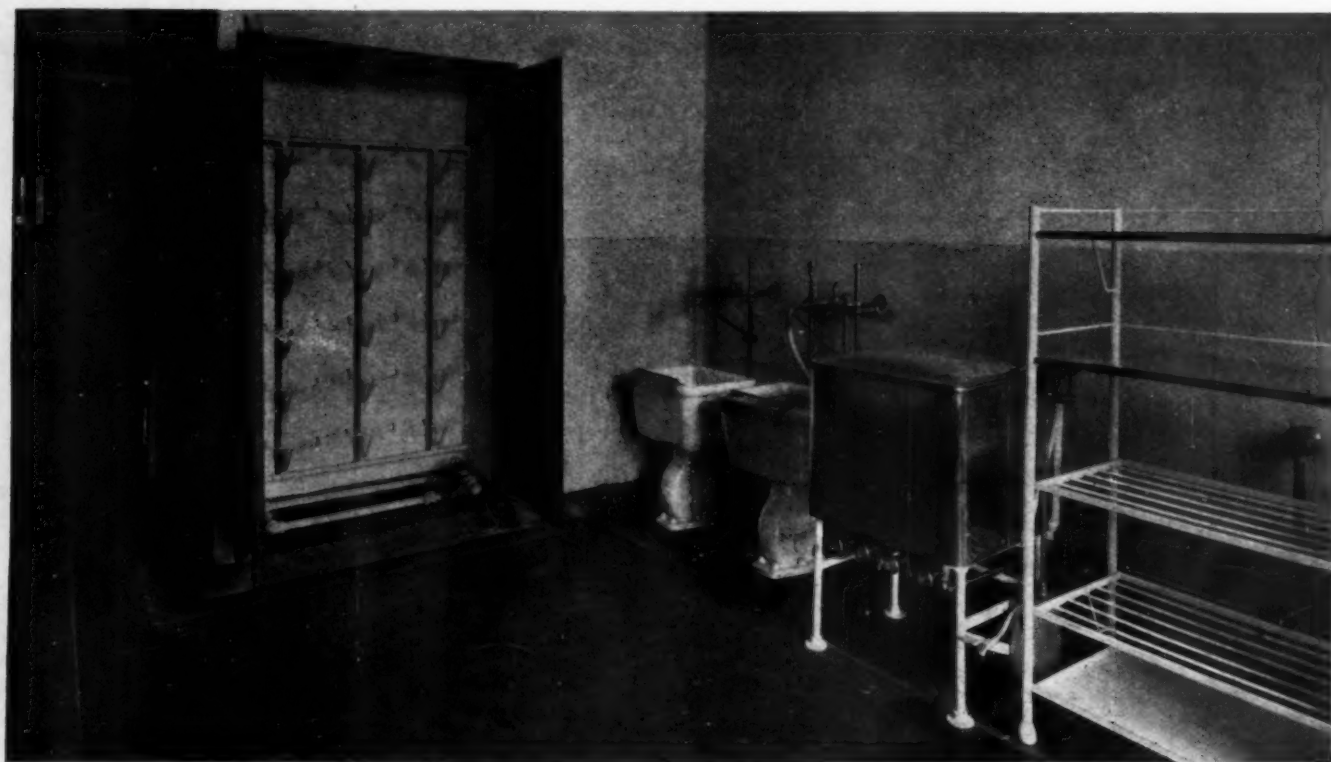
The interior partitions are constructed of terracotta and gypsum block. The finished floors generally are of linoleum, cemented down on a cement under floor. They have terrazzo splayed base and border, with brass jointing strips. Additional terrazzo floor strips are provided under legs of beds and along walls of service rooms where there is fixed equipment. The floors of toilets, bathrooms, cleaners' closets and main stair halls, are terrazzo, as are also the toilet and shower partitions and dadoes. The operating and delivery rooms, doctors' scrub room and sterilizing room all have floors and walls of gray tile.

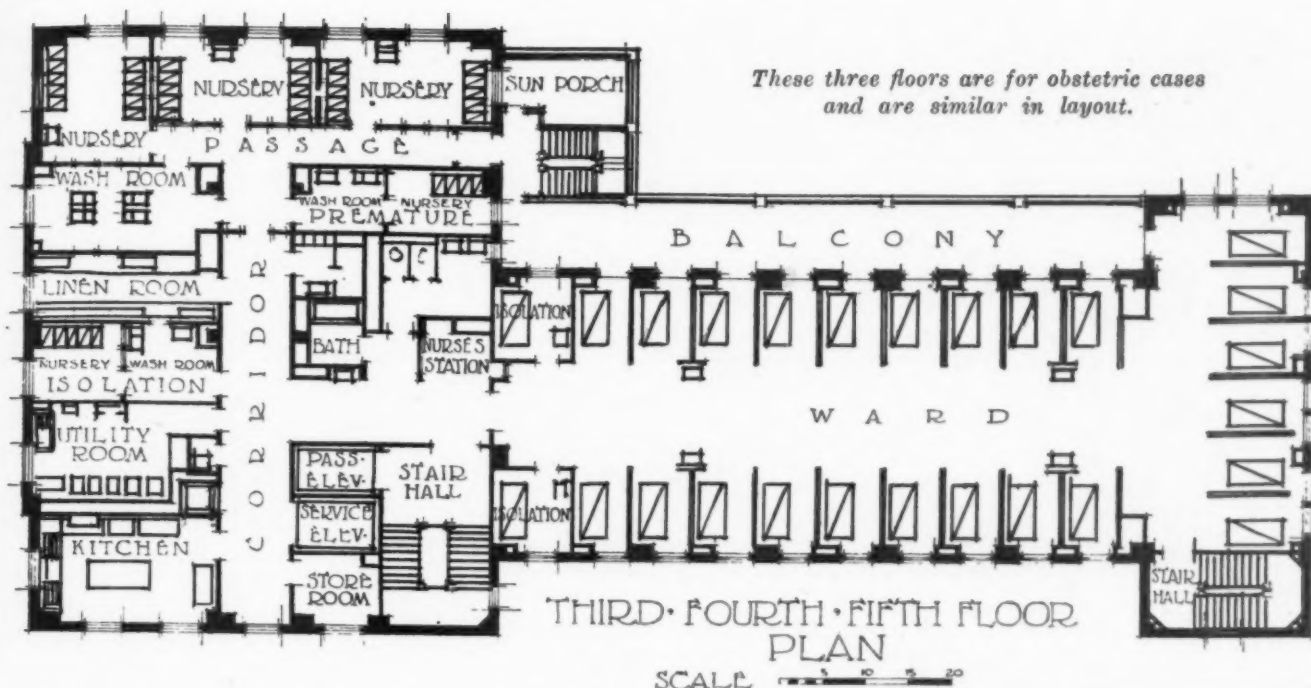


A typical ward of the gynecological and obstetric building of the Boston City Hospital, Boston. The wards are similar on all floors and accommodate twenty-four beds each



Above, one of the operating rooms of the gynecological and obstetric building of the Boston City Hospital, Boston. The floors and walls are in a soft shade of gray tile. Below is shown a utility room.





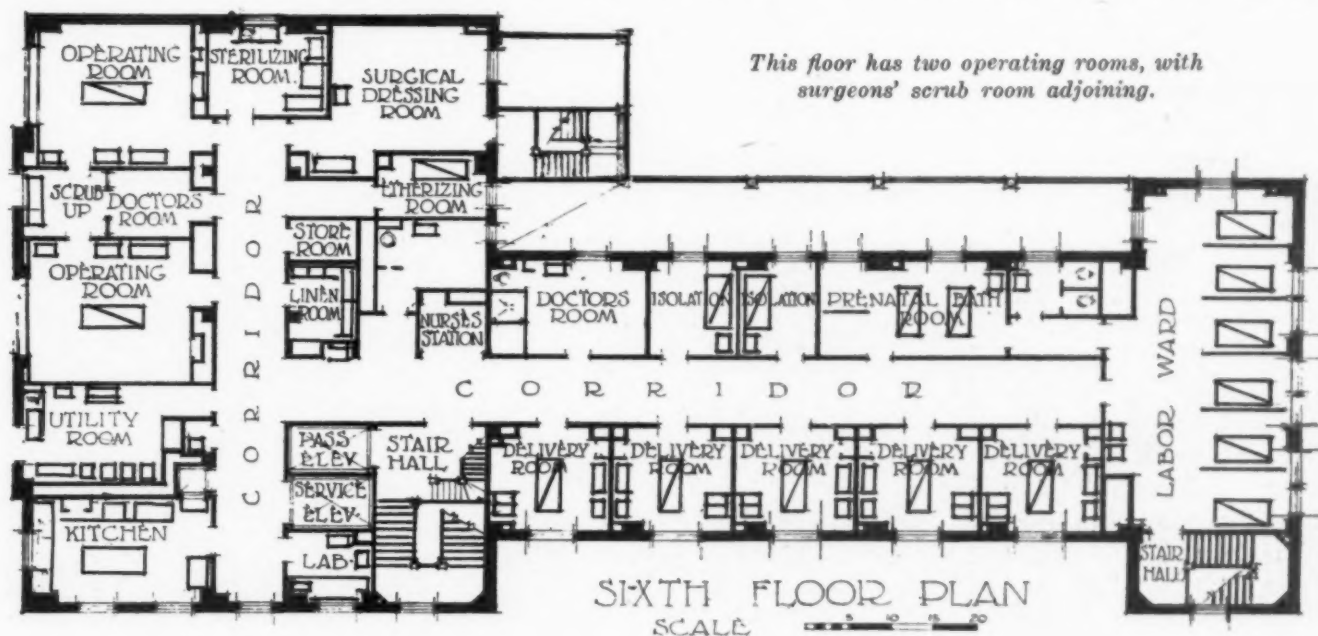
All window frames and sash are steel, with a bull-nosed steel stool fitting flush with the interior plaster. All door frames and interior sash, including trim, are steel. The doors and transom sash are of wood, and with a few counter tops and wall cases constitute the only wood in the building.

Access to the building is by means of a covered corridor, an extension of the existing system, which connects with the basement main stair hall. The top of this corridor provides an outside passageway to the main entrance door of the first floor.

The basement houses temporarily the steward's office and stores. This space will eventually be occupied by other hospital departments. It also

contains a patients' clothes storage room, a dishwashing room, in direct connection by dumbwaiter with all serving kitchens, a large store room, a meter room, an engineer's service room and a students' locker room and toilet. The stair hall of the basement and the dishwashing room are faced with buff colored salt-glazed brick, the dishwashing room having a slate tile floor.

The first five floors are given over to wards, the operating and delivery rooms being on the sixth floor. The wards, lying northeast to southwest, have a similar layout for all floors. They accommodate twenty-four beds each, with two soundproofed isolation rooms at the entrance of the ward. The wards are divided into cubicles by hard plaster partitions, seven feet in height, the





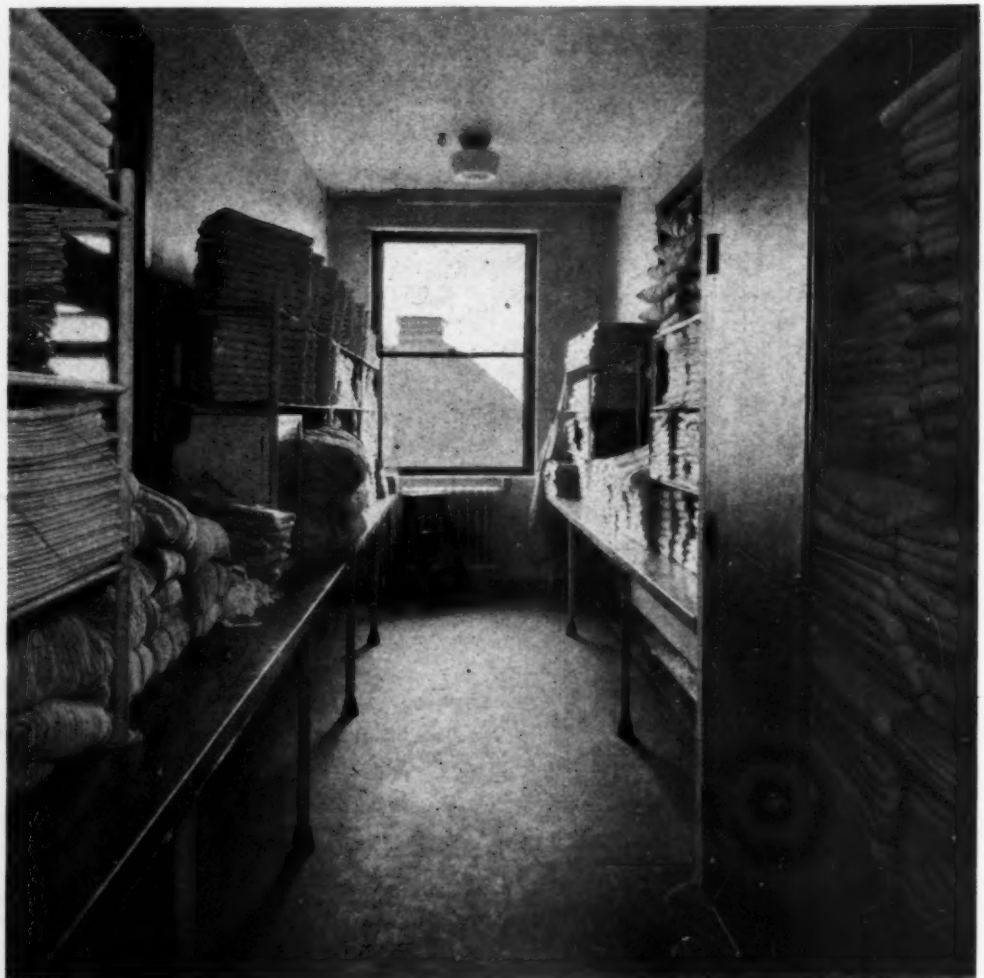
The nursery is divided into three units, separated by partitions

upper portions of which are fitted with large panels of wire plate glass, provision being made for the hanging of curtains on the cubicle frame which will give a degree of privacy to any bed. All wards have direct connection with the airing balconies.

The first and second floors are intended for gynecological cases, and besides the usual service rooms, consisting of nurses' station, patients' toilet, patients' bath, serving kitchen, utility room, linen room, cleaner's closet, nurses' toilet and storeroom, have on the first floor a small laboratory, a clinic examination room, with adjoining dressing room and a visitors' waiting room with toilets. On the second floor in addition to the usual service rooms is an examination room, with adjoining dressing room, a large laboratory and a doctors' room with toilet and shower.

The third, fourth and fifth floors are for obstetric cases and are all similar in layout. A nursery is on the north-east side, divided into three units of ten cribs each, with adjoining wash room and sun room. All these units are divided by glazed partitions with special sliding steel sash and frames, which when open throw the separate units into practically one room. In addition, each of these floors has a premature nursery of four cribs and an isolation nursery of five cribs, each having its separate wash room. The linen room is placed so as to serve directly, by means of sliding glazed sash, into the large wash room and isolation wash room. All cribs are hung in special racks, having a dividing glass partition separating each crib.

The sixth floor has two operating rooms, with surgeons' scrub room adjoining, and with sterilizing room, surgical dressing room and etherizing room nearby. A prenatal bathroom is equipped with two pre-



The linen rooms have built-in steam heated blanket warmers

natal treatment tubs and two dressing booths with hard plaster dividing partitions. This bathroom connects with a patients' toilet and a six-bed labor ward. There are five delivery rooms, a small laboratory, a doctors' room with toilet and shower, two isolation rooms, nurses' toilet and station, linen room, and the usual serving kitchen, cleaner's closet, utility room and storeroom, as on the floors below. The delivery rooms, labor wards, prenatal bathroom and isolation rooms are soundproofed.

In the roof pent houses are the elevator machine room, fan rooms and still-room for furnishing sterile water to the operating and delivery rooms. Two elevators are provided, one for service use and one for passengers; they may be used interchangeably if necessity arises.

Mechanical exhaust ventilation is provided in all wards, service rooms, toilets, baths, sterilizing rooms, laboratories, etherizing room, operating and delivery rooms. The operating and delivery rooms only are supplied with filtered warm air.

An electric refrigerating unit is installed in the refrigerator of each serving kitchen and operated by a compressor placed in the basement. The kitchen table has iron pipe legs, a monel metal top with a tray rest underneath, built of aluminum rods. A built-in steam heated, bedpan rack is provided in the utility room. Linen rooms are equipped with built-in steam heated blanket warmers, and counters supported by iron pipe legs and having monel metal tops. The shelves above the counters are removable. They are made of aluminum rods, and rest on metal pipe supports.

The nurses' call system is operated from a push button at the patients' bedside, which gives an audible signal and simultaneously lights lamps at the nurses' station, serving kitchen, utility room and linen room. These lamps remain lighted until the nurse resets the system at the bedside. The doctors' call system is an extension of an existing loud speaking telephone system operated from the telephone switchboard room of the administration building.

Electric clocks are placed at convenient points in all corridors and in operating and delivery rooms. They are controlled by a master clock in the visitors' waiting room. The operating and delivery room clocks are equipped with a large red second hand.

Radio outlets are installed at the head of each bed, except on the sixth floor, making it possible



One of the five delivery rooms

for any patient to be supplied with head phones.

Two fire alarm stations, which will connect with the city's fire department, are on each floor. Two fire hose cabinets are provided on each floor, one in the corridor and one in the ward, and although the building is fire-resistive a sprinkler system is installed with outlets throughout the entire basement, in elevator and stair wells, and in all service rooms, laboratories, wash rooms, and toilets, above the basement.

Steam and electric lines are brought to the building through a concrete underground tunnel, large enough to allow the passage of a man, connecting with an engineer's room in the basement. The building was erected at a cost of \$571,960.

WHICH SHALL IT BE—\$5 A DAY OR \$5 A MONTH?

The recent report of the United Hospital Fund of New York says that the chief hope of substantially reducing the economic burden of hospital service to the patient or to the public—and this hope is a substantial one—is through preventing the necessity of resorting to the hospital by treating disease in early and non-incapacitating stages. The usual cost of hospital service in New York City is five dollars per day or more, besides the fee of the physician or surgeon. The cost of high grade out-patient service, also without including financial remuneration for the physician, is about five dollars a month (a weekly visit). Five dollars a day compared with five dollars a month!

Out-patient service can be developed so as to furnish efficient medical care and remuneration to clinic physicians, at a cost to the patient which is substantially lower than the expense in individual private offices for equivalent service.

AN INSTITUTION THAT GIVES SERVICE TO HANDICAPPED CHILDREN

By Rose J. McHugh, Director of Field Studies, Department of Social Action, National Catholic Welfare Conference,
Chicago

SIXTY miles from Brooklyn, N. Y., in the rolling hills of the North Shore of Long Island which borders on the Sound, is the main unit of the St. Charles Home for Blind, Crippled and Defective Children.

A little more than twenty years ago five members of a French religious community, known as the Daughters of Wisdom, arrived at a neighboring village, exiled from their mother country by religious persecution. They were without any resources and attempted to earn a meager living by teaching.

It was in 1907 that the public charities sent to the Roman Catholic Orphan Asylum, Brooklyn, five crippled children. They were homeless and in need of specialized care which no institution in the diocese was equipped to give. Bishop McDonnell then presiding over the See of Brooklyn, asked the Daughters of Wisdom to take the children. They did so at once and shortly after three of the Sisters rented a house in Port Jefferson where soon twenty children were under their care. This was the modest beginning of an institution whose service to handicapped children in need of individualized treatment gives it distinction.

Medical and Surgical Treatment Given

The plant consists of a reception home and hospital in Brooklyn, which was opened three years ago, and the hospital and home at Port Jefferson. Both are completely equipped to give medical and surgical treatment to crippled children. The dispensary is in the Brooklyn institution. This building can give bed care to fifty children. A roof garden and porches enable the children who may be here for many months to spend several hours out of doors. All braces and appliances for both hospitals are made here. The dispensary is an important element in the hospital plant, serving not only to bring into the institution the neediest cases but to give treatment over long periods, if necessary, to those children who can with safety be left in the community.

The buildings at Port Jefferson are situated on forty-nine acres of rolling ground within sight of the Sound. Twenty-one acres are used for the buildings and playgrounds. The orchards cover eight acres on the west slope. A few acres are

used as a farm to supply products for the use of the institution only. There are two main buildings, the old and the new, and an auditorium. Apart from these and almost entirely concealed from view by trees and intervening hills, are four smaller buildings, which are used to house the mentally defective children. The main buildings which serve as a hospital and school for the crippled and blind children and a home for the Sisters' are of Mission architecture with a French tile roofing. They house now 220 children and forty-nine Sisters.

Dormitories Have Porches

The new building is well planned with wide corridors, sloping stairways protected by double rails, adequate elevators, lavatories in connection with each dormitory and attractively arranged classrooms and music rooms. A fully equipped operating suite and x-ray rooms are on the top floor of the new building. The sterilizing room adjoins the operating room but has no connecting door. All apparatus is operated by electricity. The treatment rooms where massage and electric treatments are given and a twelve-bed recovery room for surgical cases only, occupy the remaining space on this floor. Each dormitory has diathermy apparatus and treatments are given by the Sister in charge, under direction of the medical staff. All dormitories have enclosed porches where certain children sleep in the open air. A central oil heating plant provides heat for all buildings on the ground.

All cases enter the hospital through the dispensary in Brooklyn. When patients enter they are given a complete physical examination and quarantined for three weeks. Major surgical operations are performed and the patient is sent to Port Jefferson for convalescent care. Subsequent medical and surgical care which may be necessary is given here and the child kept until his physical condition is improved as far as is possible. It is the policy of the hospital to accept for care only cases that may benefit by treatment. Few if any children under sixteen are discharged until they have achieved reasonable progress in school and the social worker has satisfactory evidence that the home conditions to which they are returning will provide the protection they need.

The medical care at both hospitals includes the taking of all standardized laboratory tests on admission and during treatment as the need arises.

Once every two weeks children are weighed and measured. An excellent system of medical records is maintained and a complete history of every child is recorded. After operation the children are usually discharged from the operating room floor in twenty-four hours, to their own dormitories. The education of the children in caring for themselves begins immediately. They are encouraged to do as much as possible for themselves. They are out of doors a great deal and the schoolroom windows are kept open during much of the school period so that they are in the open air most of their working day.

At the first examination all muscles are tested and the results carefully charted. Treatment by massage, by the diathermy machine and by other methods, and in the swimming pool, is prescribed as indicated. Though careful records have always been kept of the treatments at Port Jefferson, a new method has recently been introduced which the medical staff believes will give more scientific data on the results of treatment. Movies are now taken of all poliomyelitis patients to discover the degree of activity that may exist in the muscles before treatment and at periodic intervals after treatment, to reveal any improvement. In a group of poliomyelitis cases successful results have recently been obtained by transplanting muscles to improve the mechanism.

Every Child Medically Examined

No child seeking care is turned away until a thorough medical examination is given. Accurate notes are made of the examination in the dispensary and if the child's condition is not considered a suitable one for treatment in the hospital, a letter is given to the person who brought him referring him to a hospital or dispensary that can give the needed treatment. A similar letter is sent to the institution, containing a report of the examination at St. Charles. When a child is sent to Port Jefferson, a duplicate of all records pertaining to his condition and treatment in the Brooklyn Hospital accompanies him. All cases not accepted in the hospital but referred elsewhere for treatment are followed up by the social workers until the patient is under the care of the proper agency.

The St. Charles Hospital has a specially equipped swimming tank for therapeutic purposes. It is forty feet long and varies in depth from two and one-half to four and one-half feet. It is of tile construction and there are low tread steps built into the shallow end, up and down

which the paralyzed child is taught to walk. The effect of the water on inactive muscles is to hold back the stronger and give the weaker ones a chance to function. The paralyzed child therefore almost immediately discovers that he can not only stand in the water but can walk. An iron oval frame attached to the ceiling holds small movable cranes from which are suspended two metal hooks. Each child who has not yet learned to swim wears a canvas corset to which these hooks may be attached, one on his chest and the other at his back. This arrangement gives perfect freedom and a sense of security to the child until he learns to swim alone.

Treatment in Pool Twice Weekly

The treatment in the pool is given twice a week to the children who need it. The muscular treatment is based on each child's individual needs and is directed by the Sister in charge for ten minutes. Ten minutes is then allowed for play. At the conclusion of the exercises all children are directed to walk around the pool and up the stairs. Since it was installed last October eight children who had been in the institution from two to five years, and during that time were unable to walk or stand, have been taught to walk without crutches by this treatment in the pool. One hundred children are now receiving treatment. They learn to swim rapidly. The first group of children who were put into this pool were told that if they did not learn to swim in two weeks other children would be given their places. Not one child failed to learn in that time.

Filtered water only is pumped in to the pool and adjacent to it are separate showers and dressing rooms for boys and girls.

The hospital cares for free and pay patients. Charges for dispensary treatments, ranging from twenty-five cents to a dollar each visit, are made according to the ability of the patient to pay, if free treatment is unnecessary.

The social service department of the hospital investigates home conditions before any child is discharged. Follow-up care for dispensary cases under treatment and for hospital cases before and after discharge is part of the routine work of this department. The readjustment of the child to his home and community after a long period of hospital care is made easier for him by the social service worker. Whether he goes back to school or into industry, this follow-up service by one who has known his difficulties in the hospital and can interpret to him the world beyond in a simple way is an essential part of the hospital treatment.

The painstaking and intelligent care given the

children is particularly apparent in their spirit of independence and self-help and their kindness to each other. The blind are guided at critical moments by the crippled and all the children are subconsciously alert to opportunities to help one another. They are taught in every way to care for themselves, to swim, dance, play games, participate in entertainments and in the orchestra.

The school equipment is modern and complete. The Sisters teach the Braille system to the blind children who participate in all the class work instruction and in the arts and music classes with the other children.

The vocational training is well adapted to the special needs and talents of each child and to his probable chances of earning a living from it after he leaves the institution. Every child is taught music and given the utmost encouragement to develop even the least talent for it. Art, handcraft, sewing and other forms of manual arts are taught in some degree to all students and more complete instruction is given those who show special aptitude in any one subject. Commercial subjects are also taught. Handwork is taught to bedridden patients.

Consultation Between Teachers and Nurses

There is effective coordination between the physical and vocational reeducation of the children. When a child first enters school the staff doctor at Port Jefferson directs through the nurses the kind of handwork he believes the patient should have at the beginning. Frequent consultation between the teachers and nurses is maintained through all the child's stay at the hospital.

Several details in the important and unique care which St. Charles gives its patients have been stated above, notably its specialized equipment and plant, the use of movies in recording effects of treatment in poliomyelitis cases, and the use of the swimming pool. The institution is as complete a unit as a hospital can be today. Under a single administration there is a dispensary, a hospital equipped to give every kind of medical and surgical treatment, a convalescent home, a school which not only aims to prepare each patient to earn his living but also to develop his special talents, and a social service department to give direction and service to each child as his condition requires after he goes back to the community. No detail in all the routine care is unimportant.

It is more difficult however to describe the more intangible methods by which such obvious results as the happiness of the children, their self-reliance and helpfulness to others, their frank confidence in all those who care for them are achieved. The entire plan of treatment is based

on the recognition of the importance of the child as a social being and of his development as a self-maintaining citizen.

The staff, medical, nursing and teaching, is also a unit and directs its first efforts to winning the confidence of the child. No child is ever operated on while he is in a state of fear, or until he is convinced that every type of treatment is solely for his benefit. It is to this policy largely that the almost negligible rate of acidosis after operations in poliomyelitis cases may be attributed. The specialized training which the Sisters have received, both for nursing and teaching, is another important factor, second only in importance to their complete devotion and consecration to their special task.

GIVING COOPERATION TO THE LIBRARIAN

In a recent informal talk to hospital and library workers at the St. Paul Public Library, St. Paul, Minn., Richard Olding Beard, M.D., Minneapolis, Minn., pointed out some of the ways in which the superintendent and hospital directors can show appreciation of the work of the hospital librarian and aid in making her work practical. He said in part: "First of all, give the librarian suitable housing for her books—the tools of her work—a roomy set of well built shelving, with glass doors and a reliable lock. Make it big enough to grow into.

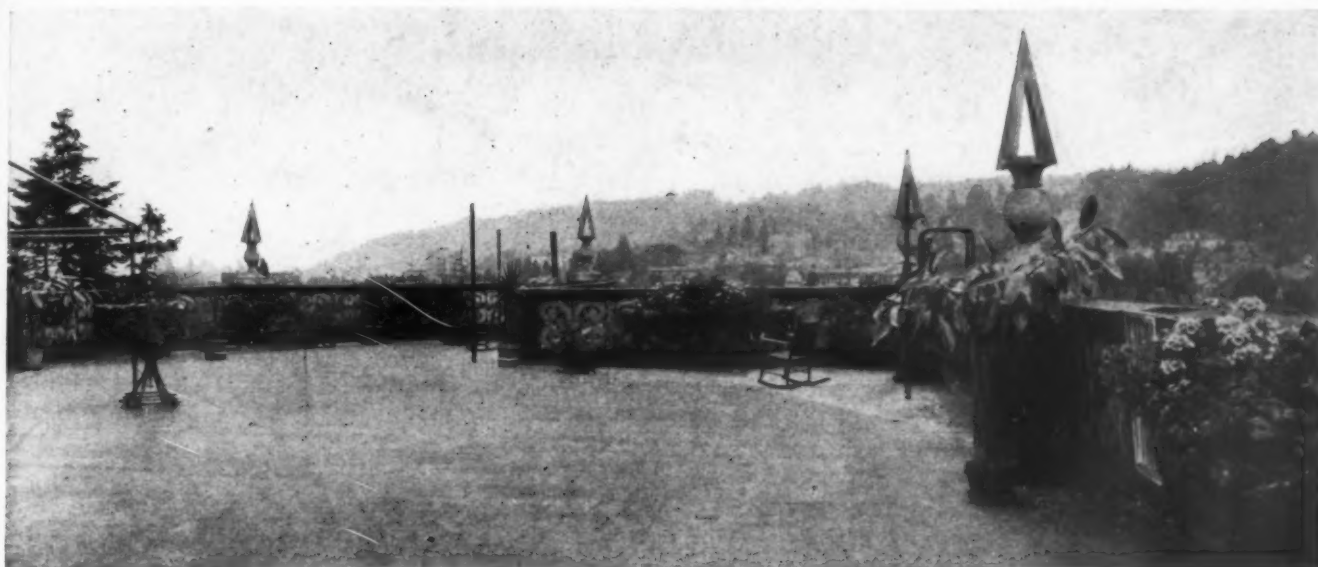
"Give her a good-sized, well finished table upon which she may sort over her selected books for bedside distribution; upon which, too, she may lay out a generous assortment of current periodicals, which you should supply—and at small annual cost.

"Give her not a dark, musty corner in the basement, not a mere cupboard in some out-of-the-way place, but a warm, sunny room, of adequate size, to serve as a reading room, in which may be put the bookshelves, the table and a few chairs, some of them comfortable, lounging chairs, in which ambulant patients may sit. Nurses will be glad to lead them there to rest, to read a while and to look at pictures.

"Get your women's auxiliary—every hospital should have one—to provide some bright chintz curtains, a table scarf or two, a couple of green shaded reading lamps, to give the place a homelike atmosphere and a touch of grace. Encourage the hospital family to come there, at the librarian's hour, to look over her books and select their own reading.

"Then, another thing, hospital administrators, put a small item in your annual budget, year by year, to replace the books that are dirty and worn with institutional use and the books that your patients and your staff lose or forget to return. You are served by a public library, you say? Yes, and some gratitude is due for that service. It provides you with a hospital librarian, and some messenger or delivery labor and with some books. But public money is always meager money. There is not enough to go around. It does not go far in buying new books. And books, almost unbelievably, wear out.

"Encourage its service to you; keep an encouraged heart in your librarian. Make her work worth while. Twenty-five, fifty or a hundred dollars a year, according to the size of the hospital, will help to give you the use of more books and of better books all around."



Roof garden, Good Samaritan Hospital, Portland, Oregon

PROVIDING A SUBSTITUTE FOR THE SPECIAL NURSE

By Emily L. Loveridge, Superintendent, Good Samaritan Hospital,
Portland, Oregon

PATIENTS care little how you get them well as long as you do it, but they do care about being made comfortable and having their immediate wants receive prompt and efficient attention.

The nurses who especially appeal to sick persons are the ones who rub their backs, adjust their pillows, give them a drink, change their position to a more comfortable one—in other words the nurses who give them what they want when they want it; also the ones who stay by them when they are suffering from pain, nausea or some other of the unpleasant sensations of illness.

The sufferer is more interested in details of his comfort and convenience than in what the pathologist finds in his excreta or the chemist in his blood. I am quite sure that if you said to a patient, "You may have your choice between having this specimen examined in the pathological laboratory or yourself fixed up and made comfortable," he would reply—"Specimen examined, of course, but fix me up first." In the patient's mind there still persists the idea that the work done in our laboratories is purely for the doctor's benefit, hence the patient prefers the bedside care at the expense of the x-ray, pathological laboratories or physical therapy departments, even although he may recognize, as we do, that the scientific work is of more vital and lasting importance than personal comfort.

All of us recognize that today far more nurses are required than were formerly necessary. The

nurse who once cared for four or six patients now cares for two or three. This is largely on account of so many demands being made on the time of the nurse, other than bedside care. Keeping charts, making reports, and preparing lists, take up a large portion of her time and attention. Then, too, the interest of the nurse is absorbed by all these details, and as a result complaints are heard that the nurse of today is less interested in her patient as a human being; that she has more skill but less heart than her predecessor. The reason of this often is that while she is at the bedside she is mentally "lining up" the service she has to render in the chart room, and so her attention is divided.

On account of all these demands there is a need for more nurses in training and more graduates on general duty. Over these we need more supervisors, and, down the line of service, to minister to these, more cooks, waitresses and maids. Also, in regard to the housing problem, more room. All this means more money.

How are we to get this money? Are there large endowments which can be turned that way? Or rich benefactors who will give sums to maintain and endow every department? Are you a city or county institution whose taxpayers willingly or unwillingly foot the bills? If your help comes from none of these sources the expense must be met out of the pocketbooks of the patients, as hospitals always have to face a reckoning with those first-of-the-month bills.

But to leave money and come back to service, today maids are employed for many things that were formerly considered to be nurses' work—dusting, cleaning and so forth. This helps the situation. Then more graduates are employed on floor and general duty; this also helps, especially if there is a school of nursing. Against this, the material from which we make the trained nurse is harder to get; there is not a sufficient supply for the demand; the applicants are younger and less responsible; they cannot do so much work, even with more supervision. Sometimes the work drags or has to be done over again.

In every department of the hospital where we find patients—and at times they are in every available corner—the center of service is the most sick or the most uncomfortable one in the group. Here is where a special nurse comes in, devoting all her time to that one, who always looks to the nurse to do the thinking for her as well as the work.

Group Nursing One Solution

Now, coming to the funds wherewith to provide a special nurse we find them low or exhausted, perhaps there never were any funds, perhaps they are wasted. That does not lessen the pain or discomfort of the one to be served—the need is still there. The question is, therefore, how shall we provide a service sufficiently good so that the patient will not suffer for the lack of that special nurse, and at the end of the illness will not be faced with an empty purse or a debt that almost takes the joy out of getting well?

Multiple nursing is the first suggestion, and it is an excellent one under favorable conditions. The patients receiving this type of service must be of same sex and have the same ability to pay, and they should be placed near each other. They should not be so ill, uncomfortable or demanding as to disturb the other patients. The nurse who does multiple nursing cannot give constant attention to one patient at the expense of the others.

Let Nurse Be Tactful

But even multiple nursing costs money, unless a fund is provided for that purpose. Also, nothing quite takes the place of individual attention when one is physically "down and out." Often the psychological effect on the patient of having someone to assume all the responsibility is an important factor in bringing back health; and a tactful nurse helps a patient by appearing to let the patient have his own way while in reality the nurse is controlling the situation.

What is the best substitute for the graduate special nurse? Not the fond mothers, sisters,

friends or relatives, who with the best intention in the world will do all in their power to help the patient, but have no knowledge of the care of the sick. I shall have to confess, however, that many times we have used these helpers because the problem could be solved in no other way.

If a hospital has enough nurses in training to provide special nurses for the people unable to pay for them, not only the free cases but those of moderate means, the situation is ideal. The patient gets a valuable service, the student a valuable training. The one who does this special duty should be relieved from every other duty or responsibility, even class work, and she should assume this responsibility only during the last part of her training. She should devote her entire time when on duty to that one patient. At the end of a week she will either be devoted to this work of caring for an individual patient or she will realize that special nursing is not the branch of nursing for which she is best adapted, on account of her temperament or for other reasons.

Am I treading on dangerous ground when I ask, how about training women and girls for attendants? Take a good sensible girl or woman, who, on account of lack of education or some other equally good reason, fails to qualify for a nurse's training. Give such a person a training, extending over a year or eighteen months, in the necessary bedside qualifications, also let her have instruction in some of the household problems, and she will acquire a good enough knowledge of the care of patients to give bedside care to the sick who cannot afford a graduate special nurse. She will be far better than the practical nurse of today, who is often most impractical, or than the afore-mentioned group of friends and relatives.

Small Hospitals Could Help

It is easy to say that the best is none too good for a very ill patient, but here is the situation: The patient is quite unable to pay for a graduate nurse or for two such nurses—one by night and one by day; the hospital has neither enough nurses to furnish "specials" from its force nor enough money to hire graduates for specials; the graduate nurse is not financially able to work without remuneration. Is not a person with half an education better by far than one with no education at all? Is it not the same old cry of half a loaf being better than none when there is an aching void in the stomach?

Wonderful work has been done by the Red Cross in their class work. They have thereby rendered a great service to humanity by teaching women and girls to care for their own friends and relatives. Is there not some happy medium

between this and the training of women for graduate nurses?

As to who is to give this course, perhaps small hospitals, badly in need of help, could give this course under the supervision and instruction of graduate nurses; perhaps some city or county hospitals, convalescent homes, or hospitals for incurables could do so. However it is done it will fill a much felt want.

Any girl with either a grammar school certificate or one year of high school, a person with good common sense, would be eligible for this training. This would take in many girls who for financial reasons are unable to go to high school. The course would omit most of the subjects taken by the nurse in training, but would give such instruction in bedside care, obstetrics, dietetics and other subjects, as is essential to ordinary care of the sick.

A wonderful endowment would be a fund, the interest of which would pay the salary of a graduate nurse employed by the hospital and living in hospital quarters, to do this special duty for patients not able to employ special nurses. The work done would easily compensate the hospital for the cost of the room, board and laundry of the nurse, and her salary would be paid out of the fund.

Discretion Is Necessary

We all recognize that the services of a special nurse are not necessary in some of the cases where such a nurse is employed. Sometimes even patients that cannot afford a "special" insist on having one, on the same principle that such persons demand a private room which they cannot afford, simply because their more prosperous neighbors have such privileges or because they insist upon having the luxuries of life even at the other fellow's expense. These cases are exceptions.

I wish each officer in every hospital could take the place of the admittance nurse or clerk for a time, or the place of the social service nurse, and discuss with the patient his financial problems—rent to pay or monthly installments on a home, shoes and clothes to buy, grocery bills to meet and school books for the children to be purchased. I am sure if everyone could hear these problems they would want to try some means of rendering financial assistance in these cases.

In our hospital at the present time we are renting another house, and putting on more nurses in training and more graduates to help in providing more bedside care for patients without special nurses. Other hospitals are doing the same. To do this every hospital needs more money.

WHY THE COST OF SICKNESS IS HIGH

"That improved business methods are sadly needed in most hospitals is a fact," says *California and Western Medicine* speaking editorially in a recent issue, and further:

"It is also a fact that such methods would lead to somewhat decreased costs for current service, but new services and new costs are constantly being added to hospital requirements and these contribute to the steady rise in the cost of good hospital care. The chief reason for growing costs of hospital services, however, is bound up in the increased costs of personnel and materials.

Hospital Salaries Are Low

"Good hospitals must have the services of more classes of professionally and technically trained individuals—as well as several classes of skilled and unskilled labor—than any other 'business.' These people, like those in other businesses, must be paid, and it is a well known fact that hospitals pay their executives, nurses, engineers, plumbers, painters, carpenters, accountants, clerks, and even unskilled laborers, less than they are paid by other fields of labor.

"Then, too, good hospitals must purchase some 20,000 different items of material, the prices of which are precisely what they are to other organizations or people. Grocery, dry goods, fuel oil, electricity and water must be paid for by hospitals at the same rates as are charged to other people for the same goods.

"Recently in these columns we briefed the story of a man who went to a fine hospital for two weeks, during which time he was operated on and had twenty-four-hour care at his bedside in a private room. His wife stopped at a near-by hotel; she did not have 'room service,' but her bill for the two weeks was more than her husband's hospital bill for the same length of time, exclusive of the surgeon's personal fee.

"No one has accused hotels of not being conducted by good business men and we don't hear much about their high costs for service, and yet the patient in a good hospital not only has every service that a good hotel can give, but many others that hotels are not concerned with.

"Every legitimate effort should be made, and in good hospitals is being made, to keep the costs of service as low as possible. The first requirement in the struggle for this goal is a good accounting system that will reflect all of the facts; and the next is a wise, tactful executive, or, in other words, the constant aim at better business methods, which, however, must be made as inconspicuous as possible.

"Physicians individually and collectively have many faults and so have hospitals, the chief of these lies in the broad field of economics, but to blame them for the major items involved in the cost of sickness is neither fair nor just."

THREE ASPECTS OF SOCIAL SERVICE

A student nurse at the New York Hospital, New York, has defined as follows the functions of social service as she finds it exemplified at that institution, according to *Hospital Social Service*:

"Medical social service acts as a lighthouse for the patient, the doctor and the community—for the patient, guiding him to the cure of his ailment; for the doctor, revealing social or economic conditions that may affect the patient's physical welfare; for the community, shedding light on the causes of, and the way of preventing human suffering."

HOW THE TRUSTEE'S INTEREST CAN BE STIMULATED*

By Alice P. Thatcher, Superintendent, Christ Hospital,
Cincinnati

THE function of a board of trustees in a hospital organization may be stated, concretely, to be the proper employment of the powers that belong to the board as an agent of the institution. What these powers consist of and how they should be used is not always clearly defined or understood by those who are most concerned.

Richard P. Borden, a trustee of Union Hospital, Fall River, Mass., states that trusteeship in general is a "relation involving many duties and liabilities, and these duties require the highest good faith in their execution, and often sacrifice of personal convenience." Some one has said, "It is not always desirable to be a trustee." This is especially true with regard to hospital trustees, unless by their achievements they make the time and effort and responsibility that they give and assume, worth while.

At a recent conference of the American Hospital Association the responsibilities of trustees were defined as follows:

1. To determine the policies of the institution with relation to meeting community needs.
2. To see that proper professional standards are maintained in the care of the sick.
3. To coordinate the professional interests of the hospital with administrative, financial and community needs.
4. To direct the administrative personnel of the hospital in order to carry out the above policies.
5. To establish adequate financing, both as to securing a sufficient income and enforcing businesslike control of expenditures.

In the face of such responsibilities it is need-

less to say that the trustees, composed as they advisedly are, of laymen, need wise counsel and expert advice concerning professional matters, whether they refer to hospital building, hospital management, care of patients, education of nurses or the relation of the hospital to the community.

The old adage, "Knowledge is power," is especially true when applied to hospital trusteeship, for the better informed the trustees are concerning every phase of hospital organization, the better qualified they will be to combine sound business judgment with a splendid ideal, and to meet the hard, knotty problems of budget and service, together with the demands of standard nursing schools in the education of pupil nurses.

To be in a position to discharge their duties and obligations most effectively the personnel of the membership of the board should be composed of

public-spirited persons representing varied community interests, such as far-sighted business men, able lawyers, conservative investment experts, representatives of social, religious and civic organizations, one at least who is in close touch with education in all its branches, in order that the school of nursing may arouse interest and receive advice. The board should include also a layman especially interested in public health, who has followed its progress in all its ramifications, and possibly representative architects and engineers, although this is not always considered advisable.

According to universal opinion, an active practitioner of medicine should not be on the governing board, as jealousy, distrust and friction are liable to result. However, it is advisable that one or more members of the medical staff meet

Real Donors

SOME one has said, "The real endowment of any institution is not only money, but desire and ability to meet fresh needs as they come, to set new standards in succeeding generations. Coin of that mintage can never be too plentiful among the assets of any hospital. The man who creates new needs and new desires is the best benefactor."

Trustees who constantly point out modern opportunities for advance, and insist upon meeting fully developed needs, are the real donors to any hospital. Thus, in a large measure, they fulfill their function in the hospital organization by applying wholeheartedly their time, means, business skill and experience toward the solution of the many and perplexing problems connected with the entire hospital field.

*Read at the meeting of the Ohio Hospital Association, Columbus, Ohio, April, 1927.

regularly with the board in an advisory capacity, without a vote. The relationship between these two groups is too important not to require direct contact concerning matters that affect the determination of professional policies or the establishment of professional standards, and the viewpoint of both groups must be properly assimilated.

The superintendent or director of the hospital should sit in at all meetings of the board, because he or she is the executive representative and technical advisor of the board and has control of the internal management of the hospital, including all employees and all purchases. He should, however, always refer to the board in matters of general policy and the larger financial problems.

The trustees should be able to rely upon the superintendent, who may act as eyes, ears, voice and sometimes olfactory nerve, for them. Equally, should the superintendent have reliance upon the trustees who, in working out their definite policies, will not come to the point of interference.

Why Trustees Are Criticized

Much censure and criticism have been heaped upon trustees (many times rightfully), because they are often guilty of two extreme faults: of going over the head of the superintendent and meddling with the details of the management; of taking too lightly their responsibilities and not giving enough time and thought to the hospital.

These faults are discouraging, but let us look within. Perhaps such a situation is not totally their fault or of their making since the interest of trustees is not infrequently the reflection of the interest of the superintendent. It is usually the busiest men, carrying the heaviest financial and executive responsibility, who unselfishly find time to serve on hospital boards, and such men earnestly desire the highest and best for the institution. Hence, it is "up to" the superintendent to awaken and stimulate true interest by presenting reports that will show the real achievements of the hospital, not only the financial condition and need for future development, but reports that will make the trustees familiar with the potent means used in the restoration of health and the alleviation of suffering through the latest curative processes and preventive measures.

We all recognize the splendid advance made by hospitals through their standardization program. Perhaps the time has come for the working out of certain standards for trustees. If so, and if these men put zeal into this task, we may expect as great a speeding up in their interest and their work as we have seen in hospitals during the last few years.

OVERCROWDING IN STATE HOSPITALS IS PREVALENT

That most states in caring for their mentally ill patients have had to deal with the serious problem of overcrowded conditions in the hospitals is evidenced in the daily press, according to *Welfare Magazine*. In New York State despite the great expansion caused through the erection of new hospitals there is still a need of more room according to a statement made to the press by Dr. C. Floyd Haviland, director, Manhattan State Hospital, Ward's Island, N. Y.

"We have estimated," says Dr. Haviland, "that in 1929, when all the money allotted for building is spent, there will still be overcrowding to the extent of 6,000 or 7,000 patients. In New York State there is a gain of the mentally ill above deaths of 1,100 yearly. Last year the excess reached 1,400. These figures are not abnormal, but merely an increase in numbers due to an increase in population."

Horatio M. Pollock, statistician of the New York State Department of Mental Hygiene, in a recent survey, brought out that there are four cases of legal insanity to every 1,000 population, and that during the course of a generation one person in every twenty-five becomes a state hospital resident. One family out of every seven is represented.

Besides these legally registered mentally ill persons there are five or six times as many mentally diseased persons outside of asylums, in Dr. Haviland's estimation. These facts emphasize, he said, the tremendous importance to the public of the work being done, and the necessity of making still greater efforts in the future.

Even with the improvements made, there is still great danger of fire at the hospital at Ward's Island because of overcrowding. The official capacity of the Manhattan State Hospital, which is the limit of what the institution should have, is 4,897, yet there are 6,691 patients on the island now, without counting 514 paroled patients. Of these, 3,156 are men and 4,079 women.

More Room Needed for Staff

As there is no room to house more doctors, the staff is inadequate, one doctor handling as many as 800 patients. The accommodations are such that doctors with their wives and children have to live among the mentally ill patients.

Of all the new projects, the State Psychiatric Institute and Hospital, to be built in connection with the Columbia Presbyterian Medical Center, New York, is the greatest and most far-reaching. In Dr. Haviland's words, "It is one of the most important things that has ever developed in the study of mental hygiene."

The site was given by the center for one dollar. A contract has now been let for a building to cost about \$1,900,000. The lower floors will consist of a 200-bed hospital for nervous and mental cases, selected with a view to their value as subjects for study, including one floor for children. The tenth and eleventh floors will have a service for patients still able to live at home. The twelfth to twentieth stories will be a tower for laboratories, lecture rooms, library, research work and teaching.

"The great advantage of this institution," said Dr. Haviland, "will be the opportunity to study mentally and physically diseased cases at one center. Never before has there been a mental institution in association with such a group of regular hospitals. As both mental and physical conditions are naturally interdependent, this will be of tremendous advantage to both, and is one of the most forward steps ever taken by the medical profession."



*Landscapes
That
Please*

Above is shown a scene in the grounds of the Good Samaritan Hospital, Portland, Oregon. On the right is a view in the gardens at the Cragmor Sanatorium, Colorado Springs, Colo.



WHAT THE HOSPITAL OWES ITS DIETETIC DEPARTMENT

By Lulu G. Graves, Consultant in Dietetics and Dietotherapy,
New York

THE department of the hospital that is responsible for its food service is no longer a place to be kept dark, as it once was literally and figuratively. Its service to the institution, however, is still somewhat obscure in a number of instances.¹ We have data showing that about half the hospitals of the country have a satisfactory food service, with no distinction regarding size or location, except possibly that a slightly greater percentage of small hospitals is thus favored.

These efficiently operated departments are generally well planned and equipped and are usually to be found in organizations where all departments are working together intimately and harmoniously. They contribute no small part to the health, happiness and morale of the hospital family. It is characteristic of these hospitals that they point with pride to their dietary department.

In view of this fact, it is a reflection upon those who are responsible for hospital policies and upon the dietetic profession that half of our hospitals still have an unsatisfactory food service.

Delegate Responsibility and Await Results

It has been repeatedly demonstrated that an unsatisfactory food service costs more than a satisfactory one under proper control; the difference being proportionate to the waste and extravagance. An efficient business organization having 35 to 40 per cent of its expenses incurred in one department gives to that department intelligent supervision and adequate facilities for work, then demands results. Results in the hospital dietary department generally mean good food properly cooked and well served to every unit in the organization, at a cost commensurate with the finances of the hospital, and without overburdening any group or individual.

That these results have been obtained in half the hospitals of our country is gratifying, but it is not enough. The hospital should not stop when it has put its own house in order; it has an obligation to the community. It should not only keep pace with the home, but should keep a little in advance of it in measures for maintaining health, as well as in the treatment of disease.

Living conditions have been greatly improved

in recent years, the public is becoming increasingly intelligent in matters pertaining to health and nutrition, and the housewife is trying to feed her family with an understanding of their needs.

Public interest is stimulated by articles on diet in the popular magazines and public press. For many people these articles are the only source of information on this subject, in the main they are helpful, although unfortunately they are not so in every case.

What the Nurse Should Know

The hospital through its doctors, dietitians and nurses, in the wards and in the out-patient department, should be able to help the non-professional person to discriminate between the true and the false, particularly in the rural communities. To do this the hospital must be a recognized authority, and it cannot be an authority on this subject unless its nurses and doctors have a good working knowledge of it. The nurses' training may include an excellent course in dietetics and dietotherapy, but if she does not become familiar with the practical application of the principles of these subjects in the treatment of patients on the wards, and three times daily in the dining room, it will mean little to her. Maintaining health and promoting measures preventive of disease are a recognized part of medical therapeutics and nutrition is an important factor in this treatment.

The hospital owes to its surgical and medical staff the opportunity to develop the dietetic service for themselves and for their patients. It owes to the nurses an adequate training in this subject which will enable them to meet the demands of an out-patient clinic or other welfare work, in addition to the requirements of the private patient. The inconsistency of advocating these methods in the medical and nursing departments and at the same time serving an inadequate menu in any part of the house is obvious, it is equally obvious that the teaching would lose much of its weight.

It is human nature to be little interested in the things about which we have little knowledge. The nurse who knows little of nutrition and dietetics usually assumes an attitude of indifference toward it while she is in the hospital. This may be a minor matter, unless she is caring for a metabolic patient, but after she graduates it may no longer be so.

¹ Report of committee on foods and equipment for food service, of the American Hospital Association, 1924.

A good mechanic may do good work with mediocre tools, but it is done at the expense of his time and effort and he will not do it if he can avoid it. This principle is gaining recognition in hospitals. As a result kitchens are being more fully equipped and, as a general thing, are supplied with better equipment. Equipment houses were quick to recognize the new trend and have met it promptly, improving old equipment and utensils when necessary, and providing new in generous quantities. Better kitchens should mean better service and when this is not so the hospital is not making the best use of its dietary department.

Another necessary factor is a good chef or cook. Meals can be prepared without a complete equipment, and they can be made palatable without a large supply of food materials, but they cannot be served in even an acceptable manner unless they are properly cooked.

Much is being said about hotel service in hospitals. This can never be accomplished with the present hospital attitude toward high priced chefs and the number of kitchen employees required. It may never be necessary to have in the hospital a meat cook, vegetable cook, pastry cook and so on through the list, as hotels have, or a man to clean silver, another to polish brass, another to clean tile, and a similar individual and specific service in the preparation and vegetable rooms, but it is necessary to have a greater number of people in the kitchen and a higher type of intelligence than now prevails if a hotel service is to be successful.

Direct Contact With Patients Needed

The dietary department that is being used to the greatest advantage is the one that is closely tied up with the medical and nursing department and has a direct contact with the patients. Hospitals having such a department already established have further opportunity for developing it in a new direction, for advances in dietotherapy in the medical world and the interest in food and nutrition among the non-professional have created a demand for more information. Students of nutrition are not able to meet all the problems or answer more than a small part of the questions put to them.

The hospital with its laboratories, food supplies, pharmacy and practically every facility for study, including clinical material in its wards and out-patient department, is the logical place for supplementing the work of the scientist and translating it into practical usage. Many members of the medical and dietetic staff are fitted and trained for experimental work. Interpreting nutritive

needs in terms of edible foods would be no small contribution to present day methods of treatment.

The hospital is logically the example to the community in its activities for health. The things that are said and done in a hospital are apt to be given a wide circulation. Instruction in right habits of living and right habits of eating given to patients, either in the hospital or out-patient department, may be likened to the proverbial "little leaven," but before it can hope to be a source of help to those in its vicinity, the hospital must first have within its own walls a good food service for every unit in the organization.

MENTAL HYGIENE PROBLEMS OF UTAH STUDIED

The mental State Hospital, Provo, Utah, was recently carefully surveyed by Dr. George L. Wallace, superintendent, Wrentham State School, Wrentham, Mass. The survey was made at the request of the legislature of Utah and Doctor Wallace was chosen on account of his well known ability and special training in the care of mental patients, according to the *Boston Medical and Surgical Journal*.

Conditions in Utah were found to be extremely bad in many respects. In the twentieth century there have been so many changes in state hospitals throughout the eastern states that it is difficult to realize that in the western part of the country mental patients are still considered as criminals and are put into the jails before being committed to the state hospitals. Apparently it has only been recently realized in Utah that people with mental disease should be considered as sick persons and not as criminals.

Doctor Wallace in his report to the state legislature strongly advises a change in the state law and suggests that the new law be modeled on the Massachusetts commitment law. In addition to the inadequate commitment laws, Dr. Wallace found a number of bad conditions in regard to the care of patients. He carefully inspected not only the state hospital, but the state industrial school, the state penitentiary and other public buildings. He found that the mental state hospital was badly overcrowded and that there was an inadequate number of physicians to care for the patients.

The findings of Doctor Wallace's report were later incorporated into a special message by the Governor of Utah to the legislature, who recommended practically all the changes suggested by Doctor Wallace.

BUY ON A YEARLY BASIS

It pays to buy towels, sheets, general bedding, soap and cleaning materials on the basis of a year's supply, for it is obvious that quantity purchases make the selling cost lower. The superintendent of a New Jersey hospital follows this plan but finds that the companies from whom he purchases are willing to make the shipments each month, as the goods are needed, and bill him ten days after each shipment has been made. This is an ideal plan for it saves the time of the one who does the buying, keeps the inventory down and saves space, depreciation and bookkeeping.

GOOD FORM—A FACTOR IN THE NURSE'S SUCCESS

By Wanda M. Caswell, Social Director, St. Mark's Hospital,
New York

PIONEERING has never been popular; it is never a mass movement. On the contrary, the pioneer is a figure conspicuous in his isolation, for the pioneer must possess to an uncommon degree qualities not common to the great mass of human beings. He must have vision, courage, boldness, perseverance and determination, coupled with the willingness to be a martyr to the mission he undertakes. Such a combination of virtues is rare indeed. Success spells triumph, while failure invites the disdainful indifference of a cynical public.

The school of nursing of St. Mark's Hospital, New York, is at present engaged in an outstanding pioneer effort to put into effect advanced educational theory and practice, as formulated by the foremost leaders in the educational world of our day. This effort is possible because of the cooperation of a broad-minded board of trustees, a resourceful director of the hospital and a progressive superintendent of the training school for nurses.

Keeping abreast of the best educational trend,

this administrative organization has included in the curriculum of the St. Mark's training school for nurses a course of study and training in "Good Form—Its Social and Professional Applications."

It will be observed from the title how closely the course conforms to Professor John Dewey's dictum that education must have for its aim social usefulness. This does not exclude the strictly technical and professional phases of a nurse's training. On the contrary, it includes these and adds to them a phase that all professional schools regard as indispensable factors of success. The efficient nurse not only must be equal to every challenge to her technical skill, but she must be prepared to meet the challenge of every conceivable social situation.

There is a constantly increasing recognition in the world at large of the vital part that a nurse plays in the sick room and at the operating table. Her skill and training are today accepted as a matter of course, but in the final analysis, her success in the largest measure is determined by that rare and exquisite quality called personality. And



Tea in the nurses' hall, St. Mark's Hospital, New York

this finds expression in terms of gentleness, sympathy, tact—in fact, all those qualities that are the result of good breeding and training in the social conventions that we call good form, professional ethics and etiquette. When these are translated into conduct and charm of personality, the nurse establishes a rapport that makes her an efficient co-worker of the physician, and a powerful force for instilling optimism and confidence in the patient.

To achieve this end the St. Mark's school of nursing has adopted the following syllabus as part of its required course of study. The course is conducted by the director of social activities, who utilizes the extra-curricular activities as a medium for concrete expression of the principles and truths enunciated in the lecture hall:

Good Form: Its Social and Professional Applications

- I. An Ounce of Good Form; Manners Tell Their Own Story.
 - A. Why all this ado about etiquette and good form?
 - B. An ounce of good form will avert a pound of embarrassment.
 - C. The origins of etiquette.
- II. Establishing Rapport—a Phase of Professional Ethics.
 - A. Importance of harmonious relations as a working basis.
 - B. Etiquette—a social lubricant.
 - C. The social greeting, its manner, form and significance.
- III. Good Form Like Charity Begins at Home.
 - A. Dining room etiquette.
 - B. Table appointments—their use and abuse.
- IV. Bedside Decorum.
 - A. The nurse and the patient: "Vanquishing the Glooms."
 - B. The nurse and her co-workers: professional ethics.
 - C. The nurse and the visitor.
- V. The Garb Oft Proclaimeth the Man.
 - A. Professional.
 - B. Civil.
 1. Personal appearances an index to character.
 2. Good taste a criterion of style.
- VI. Invitations: Formal and Informal.
 - A. The invitation.
 - B. The Acceptance.
 - C. Regrets.
- VII. Informal Gatherings.
 - A. Calling.
 - B. At tea.
 - C. A table of bridge.
 - D. The informal dance.
- VIII. Formal Gatherings.
 - A. The formal call.
 - B. Receptions.
 - C. Balls.
 - D. Dinners.
- IX. Etiquette in Public.
 - A. Dining in public.
 - B. At lectures and recitals.

X. The Traveler.

- A. Dress.
- B. Decorum.
 1. On train or street car.
 2. At the hotel.
 3. On the steamer.
- C. Use of facilities.
 1. Traveler's Aid.
 2. Porters.
 3. Information bureaus.

Supplementary to the foregoing formal instruction, St. Mark's school of nursing utilizes extra-curricular activities calculated to round out its educational program, in accordance with the principles enunciated by the progressive minds shaping the educational practice throughout our country. Nurses, no less than physicians, require the culture, the refinement and the social contacts that make them acceptable in the diversity of situations into which the exigencies of their profession project them. After the onerous exactions of their professional duties, they are in need of the relaxation, environmental, physical and mental, that will re-vitalize them, renew their energy and reestablish the poise essential to the demand that they "carry on."

The director of social activities meets this situation by a skillfully planned program of extra-curricular activities. The afternoon tea, served in the drawing room of the students' residence, has assumed the proportions of a popular institution. Bridge clubs for graduate and undergraduate nurses provide pleasant evenings in most acceptable surroundings. Theatre parties, recitals and lectures are always popular. Seasonal holidays provide the occasion for special festivities accompanied by the dance, formal and informal.

Throughout the activities, the inspiration arises out of student needs, while the directive force and the guiding spirit is the social director, who is ever mindful of the educational implications involved. The social phase not only provides the relaxation but it also meets the inner urge for social expression, which is an essential factor in a properly rounded out personality.

LIST YOUR LIGHTS

In even the best regulated hospitals there are times when light fuses burn out or short circuits occur. When this happens during the day it is usually a simple matter for the engineer to discover and repair the damage. When it happens at midnight things are different. It is for such an emergency that a North Dakota hospital has a light schedule. Every light in the house is listed on the chart and beside the light number and its location is placed the number and location of the fuse that feeds that light. On a shelf beside this chart is a supply of flashlights, candles and matches. This hospital is always ready for an emergency.

STUDIES ON HOSPITAL PROCEDURES

THE HOSPITAL AND THE INTERN

JULY first should be an annual red letter day in the hospital calendar, since most institutions accept their new intern class on that day. In the 578 hospitals approved for internship by the council on medical education and hospitals of the American Medical Association, interns are beginning, perhaps, the most important period of their medical lives. Four thousand nine hundred and fifty-two young physicians will be trained this year in these hospitals. The proper recognition of the hospital's privilege, and the responsibility which the advent of these young men and women represent, will mean much during the coming year to them and, to each of the patients in these institutions.

It has been truthfully said that the young physician practices medicine in a large measure as he has seen it practiced during his hospital experience. In the hands of the hospitals of this country, therefore, is placed in no uncertain way the future of American medicine.

But the business of securing and maintaining a conscientious intern staff has in it not a few difficult problems. Before attempting to hint at the solution of these difficulties, it may be wise to set down in as clear a fashion as possible just what may be said to represent the intern problem. This question may be approached from two main angles—the viewpoint of the intern and that of the hospital.

The chief difficulty in selecting satisfactory interns is the adjustment of the personality of the physician to that of the hospital. There is no doubt that certain interns who are unhappy and inefficient in one location may be the reverse in another institution. This problem is, briefly, one of matching and merging personalities—fitting square pegs into square holes. The intern desires and expects that the institution in which he spends his postgraduate year will be a place where he has an opportunity to learn much concerning the art and science of practicing medicine. He expects to be comfortably housed and adequately fed. He expects that proper consideration will be shown for his position and profession.

The hospital requires that the intern perform willingly and efficiently the duties assigned to him by the superintendent and the staff. It often expects from him a knowledge of medicine that he does not possess, and an observance of medical ethics concerning which he has not been adequately taught in his medical school. The hospital often demands the performance of work by the intern that is not professional and may be considered menial. The hospital sometimes requires that interns be good-natured and industrious when living conditions are far from satisfactory.

How can these two viewpoints be made so to coincide that friction and the injection of personalities will not replace efficiency and high institutional morale?

Methods of Choice

It has been intimated that it is of the greatest importance to exercise care in the selection of interns. Not only is this important to hospitals, but it is also eminently fair to the intern to prevent him from entering an institution into which his personality cannot be merged, so that as a result his intern year is not a happy one and hence is unprofitable both to him and to the hospital.

Several methods are in vogue: By appointment following a competitive clinical oral and written examination; as the result of an examination conducted by the individual hospital, the assignment to service being made by a central committee—the Philadelphia plan; by the appointment of externs or resident students as regular interns upon their graduation from the medical school; by the exercise of the appointing power by a board of trustees through the recommendation of a second party.

It seems that many hospitals are discarding the somewhat antiquated scheme of conducting long, written and oral examinations, and are adopting in its place personal interviews, perhaps augmented by a practical test at the patient's bedside. It can be taken for granted in most instances that men bearing the stamp of approval of any of the recognized medical schools of this country, are sufficiently equipped from the angle of acquaintanceship with modern diagnostic and therapeutic methods to treat patients in any hospital, under supervision.

Important points to be settled are the amenability to discipline and the trustworthiness of the applicant, from the standpoint of assuming responsibility. This information can usually be obtained from those who have known the young physician during a part or all of his life, the

personal interview serving only to confirm or reflect doubt on these opinions.

It is regrettable that so often one finds the exercise of what may be called personal politics in the selection of interns. In some of our best hospitals the wealth and standing of the applicant or that of his friends, determine in too great a measure his fitness for appointment, and the scholarly, less influential and less opulent young man sometimes finds it difficult to secure a place in these institutions.

Now it may be taken for granted that the appointing power of the board of trustees is undisputed and final. Nevertheless there should be no hint of favoritism or unfairness attached to the business of selecting the members of the intern staff. An institution that has had an opportunity to observe a medical student during his undergraduate days, can prognosticate, with a fair degree of accuracy, his behavior as a graduate physician.

It is of the utmost importance to observe the behavior of the young doctor as he approaches the bedside of the patient. If he displays a professional attitude, softened with a kindly understanding of the patient's psychology, and if he observes the commonplace rules that exist in regard to the relationship between physician and patient, the examiner is able to judge, with reasonable certainty, his desirability as an intern. A physician who sits on the patient's bed or unduly exposes him during examination, or is callous in his remarks in regard to the patient's illness, lacks much of having attained a working knowledge of that intangible thing that has been called the art of practicing medicine.

The Philadelphia Plan

Reference has been made to the Philadelphia plan of selecting interns. In that city most of the representative hospitals have entered into an agreement whereby the results of the examination held in each institution are transmitted to a central committee, and an attempt is made by this body to match the desires of the intern and the preferences of the hospital. This plan has much to commend it, since it not only establishes an atmosphere of confidence in the fair dealings of each institution but also eliminates undue competition, as well as the practice of individual institutions attempting to antedate others when it comes to setting the day for examination.

Whichever of the above schemes of selecting interns is adopted, it should be founded on a spirit of fair play to the intern, the hospital and to other contemporary institutions.

Physicians who have served hospital intern-

ships have indelibly stamped upon their memories the impressions gained on their first intern day. Procedures which to those who have spent the previous twelve months in the institution, appear commonplace and easily understood, to the new intern present a confusion of detail that is all but impossible to comprehend.

Explanations Should Be Made Early

The psychology of the new intern should be thoroughly understood by those whose duty it is to acquaint him with his new responsibilities. To arrange for the safe disposal of trunks and suitcases, to explain hours of rising and limits of meal hours to make known patiently and with no air of superiority the meanings of such terms as "P.R.N.," "Cutting an Order," "Signing out Deaths," "Writing for Drugs," and so forth, is to prevent the young physician from having to learn accidentally the meaning of these simple terms, because he feels it humiliating to ask.

The superintendent or the chief medical officer of the hospital usually spends most of the first day in classroom instruction, in going over in great detail the general and special rules covering the work of the resident staff. It is not sufficient to hand to each newcomer a book of instructions to learn, and to direct that he observe the rules contained therein. Each of the major hospital rules should be presented and discussed with the class as a whole. The relationship of the intern to the nursing staff, administratively and personally, the attitude of the intern to his patients, the authority of the young physician, from the standpoint of prescribing narcotics and liquors, the methods of requesting consultations, the relationship of the hospital to its laboratory and other specialty departments, and the procedures necessary to secure these specialty services, are but a few of the matters that should receive careful explanation by the hospital executive or his representative.

It is a pernicious system for new interns to be informed concerning the hospital rules by physicians older in point of service, or by nurses. Oftentimes there is a feeling of resentment aroused in the mind of the young doctor when he is told by a graduate nurse that he "must not do this," or "should do that." The intern must be so well informed concerning the rules of the hospital, that he is even a little better qualified to inform others as to hospital regulations than are those around him.

In large institutions where there are several resident physicians, the new intern class, after it has received general instructions from the head of the hospital, is subdivided into groups and

turned over to the members of the resident staff for explanation of the special requirements of the departments to which they are first assigned. This instruction should include not only explanation of rules but a ward walk, during which the new intern is introduced to his predecessor, to the nurses and to others connected with the department. The intern retiring from the service is able to inform the newcomer relative to the physical condition, the treatment, and even the special idiosyncrasies of his various patients.

It is the duty of the resident physician, or in his absence, of the retiring intern, to inform the newcomer as to the usual visiting days of his chief, and as to any other special matters relative to the chief's desires and expectations.

Methods of Discipline

In some institutions a system of discipline is adopted which presupposes that the intern is not likely to do right, and that there is a necessity for surveillance in order promptly to detect wrongdoing. While the intern is a queer mixture of schoolboy and professional man, yet it has been found by many skillful hospital administrators that this policy is less successful than one which presumes that interns will usually do right. No spy system of any sort should be encouraged. Gossip by members of the hospital family in regard to the intern's behavior should be condemned, and friction between medical and nursing staffs at once stamped out. When rules that have been thoroughly explained, and hence should have been understood and observed, are broken, punishment should be prompt and fearless. The institution that is able to establish in the minds of the young physician the assurance that, right or wrong, he will receive fair play, has gone a long way toward obviating disciplinary difficulties.

The Intern Schedule

Deans and boards of trustees of medical colleges spend much thought and energy in working out their curricula. Since the hospital in a measure fulfills the functions of a postgraduate medical course, the service schedule should assume almost the proportions of a medical college program. Definite periods of service on the various hospital departments must be set down, and the transition from one service to another must be clearly marked as to day and hour. Responsibility for patients and the carrying out of other hospital duties must be so clearly worked out that there is no opportunity for misunderstanding. Too much work must not be given, but the reverse is almost as harmful.

The intern schedule of service should be so arranged, that for every hour of the day a definite responsibility for the care for each patient in the hospital is placed on some physician. In many states, boards of medical education require definite periods of service. These experiences usually cover surgery, medicine, pediatrics, obstetrics, laboratory, x-ray and anesthesia. Attached to the service schedule is a sheet showing the time the intern is permitted to be absent from the hospital. Careful observance of this time schedule must be required.

In one institution where nine interns are on duty, it has been ruled that at least two must be in the hospital at all times. Most hospital executives feel that this percentage is too low, and that in order adequately to care for the hospital's patients, and to provide for emergency aid should fire or other unusual occurrence arise, at least 50 per cent of the intern staff should always be on hand.

General and Special Rules

Rules are essential, and no business can be conducted without them. It is possible to fall into the error of having too many rules, but once a system of hospital regulations has been adopted by the board of trustees, obedience to its letter and spirit must be exacted.

It is a fine thing for members of the hospital personnel to feel that they have had a part in preparing regulations, and hence have a duty in observing and enforcing them. The spirit of self-government, while it has its drawbacks if followed to an extreme degree, has much to commend it. For example, the staff house may be conducted somewhat on the principle of a men's club, with a house committee that is attentive to its physical upkeep and to the protection of the hospital property, in so far as others of the intern staff are concerned.

Rules must be of several types—those that cover the general conduct of the intern in the hospital, those that are usually included in standing order books, which refer to routine treatment of special diseases and emergencies, and those that may be termed "special departmental rules," covering the work of the maternity, surgical, metabolic, pediatric, x-ray or laboratory divisions. It is not feasible for the rules of any one hospital to apply in detail to another institution, and it is not the purpose of this article to more than hint at the principles underlying the compilation of such institutional regulations.

In 1922 there was issued as Bulletin No. 45 of the American Hospital Association, an excellent little pamphlet, edited by H. M. Korn, M.D., as-

sistant visiting physician of the Lakeside Hospital, Cleveland. This contained professional standing orders in force in that institution. Hospitals considering the revision of their rules covering professional standing orders will do well to consult this booklet.

Many institutions possess a more or less complete procedure book, and this is eminently useful in supplying the new intern with much detailed information in regard to the methods which he is to adopt in treating patients under his care.

The Intern and the Visiting Staff

The influence of the members of the visiting staff upon the neophyte in medicine, is perhaps more far-reaching and lasting than any other impression that he receives during his hospital year. Dr. Richard C. Cabot has recently written an interesting monograph in which he touches on the subject.¹ Doctor Cabot remarks upon the aping, often no doubt unconscious, of the methods and manners of distinguished visiting physicians by the interns with whom they come in contact. From the professional and social intercourse which the interns enjoy with their chiefs, is derived much of their knowledge concerning medical ethics and the art of handling sick people. Hence it can be said that if friction between the chief and intern arises, oftentimes the fault lies not alone with the intern.

The chief, in using the possessive pronoun when speaking of his intern, may do so rightfully only with the idea that the young physician is his to instruct, to educate. Great medical men therefore have an opportunity of perpetuating their greatness by inculcating in the impressionable young graduate some of those principles that they have found to be efficient and workable during their years of practice.

Fortnightly Conference Is Held

In one institution a fortnightly clinical conference for the intern, conducted by the visiting staff with the same care and accuracy as would be employed in an undergraduate school of medicine, is mandatory. Here the board of trustees insists that the intern's instruction be much more than a casual matter.

A problem which is recognized by medical educators everywhere, seems to arise from the fact that many visiting physicians are so busy that their time does not permit the careful teaching of young hospital physicians, and what is even more serious, that many members of hospital staffs do not realize their obligations in this mat-

ter, or are not qualified to impart the information and skill which they themselves may possess.

Boards of trustees, it seems, should recognize that it is not only necessary to choose for their visiting staffs, men who are personally skilful, but also to attempt to procure surgeons and internists who are both able and willing to impart this skill to others.

A distinguished American surgeon is said to have remarked that his idea of paradise is a place where the intern always treats his chief as his equal.

There is no doubt but that some young graduates in medicine are possessed of an inordinate spirit of self-confidence, which is but the manifestation of a youthful optimism untempered with experience. If this attitude persists, the visiting physician is, in a way, to blame for not having kindly but firmly shown the intern the error of his ways. It is of utmost importance to bring together the records of hospital interns in so far as clinical excellence and zeal are concerned, with their general deportment records. There appears sometimes a false idea of group loyalty or of professional slothfulness which prevents a visiting physician from informing the hospital superintendent relative to the clinical shortcomings of his intern.

Questionnaire Method Used

To solve this difficulty, hospital superintendents sometimes send to the visiting chief at the conclusion of each scheduled service, a short questionnaire covering the work of the intern assigned to him. This system has a tendency to correct the above attitude, and serves as well, as a means of compiling a complete record of the intern's work during his period of service. A copy of such a form is shown here.

Dear Doctor:

Dr.....has been on your service asintern for.....months. Will you be kind enough to answer the following questions regarding his service?

1. Has he been prompt in meeting you on your arrival at the hospital?
2. Has he carried out your instructions for the care of the patient?
3. Has he kept his records up to date?
4. Would you recommend him for promotion?
5. Have you any suggestions to make for the betterment of the service in your department?

Yours very truly,

Medical Director and Superintendent.

Signed

Visiting Chief.

¹Cabot, Richard C., M.D., "Adventures on the Borderlands of Ethics." Harper and Brothers, New York, 1926.

It seems to be a wise custom for interns to be required to attend monthly staff conferences, and to be responsible for the compilation of the service reports presented by the chief. Here the intern is able to learn much concerning the methods employed in conducting such a conference. He will be able to use this information in later years when he becomes a visiting physician to a hospital. Here he also learns the importance of procuring as many postmortem examinations as possible, and the need for complete and accurate case records. In the last analysis, it may be said that next in importance to the wise choice of the members of the intern staff, the attitude displayed by the chief toward the intern makes or destroys efficiency on the part of these hospital officers.

Histories Must Be Legibly Written

Some one has said that good historians are born, not made. This applies with equal truth to the chirography of young medical men. It appears no longer necessary for physicians to employ Latin to prevent their patients from reading their prescriptions. The average handwriting in English serves the same purpose. Most medical curricula lay little stress on good history writing. This fact has driven the hospital to adopt either the question and answer form, or to place marginal notations on the history sheet, so that the intern will have some idea of how to proceed. Much can be learned concerning the orderliness of the physician's mental processes and the logic of his deductions by reading the history that he prepares.

Busy medical men object to viséing and signing patient's histories, and prefer to have this responsibility assumed by the resident hospital officers. If this survey of the history is not performed until the patient has been discharged, it can be of little service from the standpoint of securing medical facts that will be accurate and reliable.

The Lakeside Hospital standing order pamphlet mentioned above contains complete data relative to history writing. In most hospitals receptacles have been placed on the wards for the keeping of histories until they can be seen by the chief, but hospital superintendents everywhere will agree as to the difficulty of promptly securing these visés. Histories are much more presentable if typewritten. In smaller institutions, this is more and more generally being done. The chief drawback is the expense entailed, which is not inconsiderable. Dictating machines have been used, but are rather too complicated to be wholly successful.

REDUCING HOSPITAL COST FOR THE MIDDLE CLASS PATIENT

In his presidential address at the annual convention of the American Medical Association, held at Washington, D. C., Dr. Jabez N. Jackson, Kansas City, Mo., made reference to the pressing need for the endowment of hospitals, more especially the endowment of hospitals for people of moderate means. Dr. Jackson spoke of the ever increasing cost of hospital service, brought about by the demands of science, expensive construction, expensive equipment, laboratory and x-ray apparatus—modern products that have changed the hospital picture from that of forty years ago. "It must be recognized as an inescapable fact," Dr. Jackson stated, "that the actual expense of hospital service is such that few can make both ends meet without outside aid."

More acute than the problem of the city hospital for the poor, which the city supports, is the problem of the private or semi-private hospital, according to Dr. Jackson, who said in part: "Hospitals of this class must not only be built by men: they must as well be endowed. It has been considered most generously charitable to build a fine hospital and give it to the church or to the community or to an independent board of trustees. It cannot be made self-supporting. A load of responsibility has been placed on someone's shoulders. It can be met only by further contribution from the same or other sources. Perhaps if it is a real charity hospital, it will be endowed."

"But what the public must learn is that for the protection of the middleman endowment is also a necessity—endowment that will at least provide for the expense of purely scientific service, a service which in itself has no direct return; endowment that will equip adequate modern laboratories such as proper service demands; endowment that will provide at least modest compensation for the purely scientific laboratory expert who has no other source of remuneration and yet whose aid is a necessity to all who practice; endowment that will meet the expense which the 'generation of science' has brought to medical service."

"Men of wealth have contributed most generously to the endowment of institutions for research, and we bow in acknowledgement of such wonderful contributions for the future good of mankind. The appeal of charity has likewise touched the heart and reached the pocket of men for contributions to absolute charity. And for such we give praise. But is there not possibly a higher service still: a service that unseen and unnamed is rendered to the man who is a man, though neither rich nor pauper—the fellow who builds a world, generous to rich and to pauper alike?"

PUBLIC HEALTH EDUCATION BECOMES WIDESPREAD

With each passing year sanitarians are coming to appreciate more and more clearly the importance of effective public health education. In many fields of endeavor our armamentarium against preventable sickness or death is available. The task which confronts the administrator is to carry the knowledge of the laboratory into the home. Public health education is a far cry from the back-yard sanitation of our early predecessors, but it is an effective tool that has been of significant service. Its accomplishments will long prevail.—Herman N. Bundesen, Commissioner of Health, Chicago.

Editorials

AN INTERNATIONAL BOND OF UNION

EXACTLY one year ago THE MODERN HOSPITAL editorially suggested that the time was ripe to hold a hospital conference that would be international in its scope.

It was predicted that, could such a convention be held, the peoples of many countries and climes would directly or indirectly receive benefit therefrom. It was stated that geographical separation or racial differences should not prove a serious barrier to the success of this project. There is no north or south, or boundary line or border, in the democracy of those who seek to alleviate human suffering.

Today THE MODERN HOSPITAL is convinced that it is the duty of some organization in this country to initiate this project. This body should be the American Hospital Association.

But the problem of securing an agency or organization in each European country, whose interest in and support of such a convention could be enlisted, is not of such simple proportions as might appear on the surface. However, there is one group whose cooperation if once secured would be, without doubt, both far-reaching and unselfish.

Whatever is one's individual opinion relative to the organization and function of the League of Nations, none can dispute the soundness of its adopted principles, relative to the prevention and treatment of disease among the people of its constituent nations.

The concern on the part of this body relative to the physical welfare of the inhabitants of southern and western Europe, was practically displayed in 1920, when a group of distinguished physicians visited the United States. They were extensively entertained over a period of several weeks by federal, state and municipal health agencies. They came by direction, and at the expense of the League of Nations, to learn of the methods employed in this country in the advancement of medical science and in the institutional care of the sick.

But among this group there was not a single physician whose sole interest lay in studying hospital construction and administration.

Now, America unquestionably can learn much from other countries in regard to public health matters, and the reverse is as certainly true. Undoubtedly America can and should con-

tribute much to other nations relative to modern hospital construction and efficient administration.

Since the hospital is the pivot around which preventive medicine, in all of its educational phases, should revolve, the mingling of hospital workers of all nationalities would certainly advance the care of the sick everywhere. It would do more. It would create a healthy international understanding among those participating, because in thinking together of the welfare of others there could be no suspicion on the part of anybody of the existence of selfish motives.

Perhaps such a conference might be sponsored by the League of Nations and held in the League Palace in Geneva, Switzerland. If such a motivation and stamp of approval should appear to some to possess an embarrassing political tinge, the place of this convention could be elsewhere.

No doubt to encourage the meeting of other international nursing and medical organizations at the same place and time would serve to swell the sum total of interest and of profit derived.

Whether the first international conference should be held in this country or abroad, is a matter which, no doubt, will be wisely decided, should the project be favorably received by the lay and professional public. There is one point upon which there can be no debate: the American Hospital Association should be the body to initiate and carry to an undoubtedly successful conclusion this interesting and progressive plan.

LINDBERGH AND HOSPITALS

AN INTREPID boy, an improved airplane and good landing conditions conspired to produce a trans-Atlantic flight that threw the world into hysteria and made a bold advance in aerial navigation.

The modest, levelheaded personality of the hero of this flight has contributed to the perpetuation of the results of his accomplishment. Thus man is overcoming the stubborn and treacherous obstacles of the air and is wresting from Nature the answer to her secrets.

May not the effect of this flight upon medical and hospital practice be stupendous? The world has learned that flying, once so hazardous, is now relatively safe, and in a few years it may be no unusual thing for a patient to be put into an aerial ambulance and carried three or four hundred miles for hospital treatment. The practitioner in the country and smaller cities may devote himself largely to diagnoses and the treatment of minor ailments. Hospitals in the smaller communities may become receiving hospitals, and there may be created large medical and

hospital centers that will draw from an area whose radius will equal the maximum flight of an aerial ambulance.

In this way every patient would have the opportunity of quickly and easily getting into contact with the best minds of the medical profession and of receiving the most careful hospital care. It would mean larger hospitals, improved methods of care and treatment and the stimulation of the entire group whose duty it is to care for the sick.

SALES AND SERVICE

THE purchaser of an automobile usually measures its desirability not only by its reputation and evident sturdiness of construction, but also by the service or promise of service that the seller offers. This service, to be satisfactory, must consist of a continuing interest in the motor and its mechanical condition long after it leaves the salesroom floor. Periodic inspections are often supplied gratis, and after a varying period of months opportunity for a general overhauling is insisted upon by the dealer.

The hospital has the same obligation to its patients, present and past, though in a much greater degree, as has the automobile dealer to his clients.

The prospective patient is perfectly justified in inquiring not only, "What can and will this or that institution do for me now?" but also, "How continued and effectual will the hospital's efforts be in safeguarding me against a return of my present condition?"

How futile are marble halls and skilled staffs if the patient is to be forgotten or slighted after he crosses the institution's threshold on his way home! Then, if ever, in the case of the ward patient particularly, does he need the advice and counsel of the hospital's staff.

One wonders whether the hospital always realizes that the price of a ward bed should include the same sort of service guaranty as does the original price of the motor car.

This service will consist of periodic examinations; counsel as to the relation of employment to the patient's physical defect, whatever it may be; advice as to his personal hygiene, and a real and sincere interest in maintaining him, from the physical standpoint at least, as a useful member of society.

Nor does the payment or non-payment of a hospital fee alter in any degree the moral obligation of the institution in this matter. The social service staff must play a large part in fulfilling this hospital function. And to do this the department must be truly medico-social, and not largely financial in its activities.

To hand each patient as he leaves the hospital, figuratively at least, a guaranty of continued service, is to meet fully the institution's obligations to its patients.

WHAT SHALL WE DO WITH THIS MAN?

THERE should be a "Committee for the Correction of Misinformation About Hospitals."

From time to time and from sources wholly unexpected come weird tales regarding hospitals, and unfortunately these statements usually go unchallenged. That the men making these assertions should know better, and don't, strengthens the argument for the prompt refutation of charges of inefficiency in hospital management. Exorbitant costs of hospitalization, outrageous salaries paid to nurses and other "space grabbing" statements are made designedly to get into the public press, even at the expense of hospitals and the medical profession itself. This constitutes unethical practice, just as does the broadcasting of unsubstantiated statements regarding medical practice.

If a physician publicly proclaimed that vaccination was a fraud and physicians charging for inoculations were thieves, he would be ostracized by ethical practitioners. Yet a man high in medical councils recently stated that present-day nursing was a mere sham and that nurses were too well paid.

What should be done with him?

TALKING IT OVER

THE pendulum of one phase of medical education is swinging back. Years ago the neophyte "read" medicine with a wise and dignified gentleman of the old school. From him he absorbed many valuable lessons in ethics, economics and medical science. At the University of Wisconsin, Madison, Wis., the senior medical student is being brought into a close relationship with his instructor, not only in the classroom but in serving as the assistant in his teacher's private practice. Is it not possible that in the past an unwise attempt has been made to replace entirely this sort of experience by service in the hospital?

* * *

THERE is much being said today about the science of nursing, but let us not forget its art. The nurse may be as wise and as skilled as the fabled Panacea, but if her hands are icy, her footsteps heavy, or her tongue too facile, her virtues avail her not. And she, who jocosely asked the unspeakably hungry fourth-week typhoid patient on Christmas day how he liked his turkey dinner, should have been cast into outer professional darkness.

Then there is the "I-once-nursed-a-patient" nurse. It is she who describes in detail the rupturing of thoracic aneurysm—a topic of intense interest to the physician, perhaps, but wholly inappropriate as a subject of con-

versation with the man who unfortunately is afflicted with a dilated aorta. Some nurses are veritable special editions of an institutional paper, knowing as soon as it happens all the gossip of the hospital. Others issue frequent bulletins to their colleagues relative to their patient's peculiarities, past history and present personal affairs. Thanks to the excellence of most of our schools of nursing, these incidents are not representative, but when encountered they do irreparable harm to the reputation for tact possessed by the great bulk of graduate nurses.

* * *

IT IS said that Lister used to say at the beginning of an operation, "Let us spray." In the care of hospital trees and shrubs a similar exhortation should be used. A great variety of parasites and other pests seem to be in league to destroy beautification and landscaping. Well selected sprays intelligently applied at frequent intervals will do much to improve and preserve hedges, trees and bushes.

* * *

DO YOU ever wake up with a grouch—a deeply jaundiced grouch that makes the apple of life as tasteless as a raw potato and makes you feel that the sweetness of existence has been fermented into the vinegar of disillusionment? If you are wise, you will regard this as a "stop, look and listen" sign, a flash that should notify you that all is not well with your physical and mental machinery. Perhaps it's a dietary indiscretion that has draped you in this pall of gloom; maybe fatigue is responsible for it; possibly it is just a plain indigestion of the job; boredom may be the etiological agent. In any event, the cause should be sought and relieved. Mental catharsis may be indicated; a stiff dose of exercise may be required; perhaps a day of frank idleness may be the remedy. Perhaps the cure may come from someone else. A pleasant word, a sunny smile, a tactful compliment—how they smooth out a grouch! An appreciation of this helps in our attitude toward the grouches of others.

* * *

IF YOU sit around listening for opportunity to knock at your door you are apt to strain your ears and grow old in waiting. Watchful listening may be a grand theory but it doesn't work out practically. The only opportunity worth while is the one you make. This requires initiative—the ability to start something, and delivery—the ability to finish.

* * *

WHEN certain chemicals in solution are brought together a base or precipitate is formed. This action is rather constant. When certain dispositions are afflicted with disease, the result is not so certain. We may see cheerfulness and bravery, or discouragement and fear, manifest themselves in sick persons who present just the opposite traits when in health. To those who do not understand these varying reactions there may come a response that will be unfair to the patient. The psychology of the sick is a subject about which all of us should know more. The psychology of the well—of the relatives and friends of the sick man—needs also much study. The anxiety of the wife of the patient may lead her to do and say things that would be entirely foreign to her nature under ordinary circumstances.

To make allowances for the fears, hopes and aspirations of both the sick and the well, is the first lesson that the

doctor, the nurse, and the hospital superintendent must learn.

* * *

IT TAKES twenty-one days to hatch a hen's egg and so far as is known neither hens nor men can alter this. It's the same with men and women; a certain period of incubation must elapse before they can hatch into real people. It's so with ideas; they may spring fully formed from the brow of Minerva but not so with human ideas; they've got to be fertilized and incubated for quite a while before they hatch and even then they have to be safeguarded to maturity. Time does the trick with eggs and ideas; if you try to hurry an egg, it turns out rotten; it is even so with ideas.

* * *

YESTERDAY is dead.

Tomorrow is unborn.

Only today lives.

Yesterday's mistakes are buried.

Yesterday's good deeds are immortal.

What we do today may die or live forever.

* * *

THERE are a lot of people who take themselves so hard that they ought to be chocolate-coated. This is a sort of defense reaction, a kind of whistling as they pass through the graveyard of their buried aspirations. Taken at their face value, they are Nature's most wonderful product, springing from the noble ancestral tree and destined to be the arbiters of fate. Would that they took their work as seriously! Alas, no! they are the people who have never learned that bare hands get a lot firmer grip on success than do kid gloves, that the word success comes from *sub cedere*, to move under, to follow after; in other words, if you don't get under your job and follow it up, it isn't success. Usually these serious ones are in the market for a position which they will "accept," by preference something about as soft as a mattress tester's billet, but even at this they rarely do well. They are those who have never found out that "there are purple grapes in the land of Git-Thar."

* * *

SPEAKING of justifiable homicide, the chronic appointment-breaker is nominated for a seat in the tumbrel. The habitually late manifest an irresponsibility that endangers integrity. An appointment is a contract and as such an obligation. Those who wish to have a reputation for reliability must be prompt. If they are not, they mark themselves as not wholly dependable. Perhaps this is harsh but at any rate, such persons are among the world's prize nuisances.

* * *

SOMETIMES even old Mother Earth gets tired and needs a rest. The wise agriculturist then plows the field and lets it lie fallow for a season, soaking up the rain and sunshine. It is even so with human minds and souls. About every so often it is a good thing to cease cerebration and soul searching and let in the rain and sunshine of sheer animalism. The lakes, the woods, the mountains invite us; bees, birds and flowers await us and it is good for soul, mind and body to commune for a while with nature under the hedgerow. We hospitalers do too little of this. We give of ourselves always and put little back until finally nothing but our empty shells remain.

The Modern Hospital Reading Course: Lesson VIII

HOSPITAL BUDGETS IN THEORY AND PRACTICE

By C. W. Munger, M. D., Director, Grasslands Hospital,
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THE modern business principle of expense budgeting is analagous to the careful study made by the scientific medical practitioner in diagnosing and planning for his patient before any treatment begins.

Just as the careful physician demands knowledge of the condition and physical needs of his patient before he decides upon a course of action, so must the hospital head take stock of the financial condition and future financial needs of his institution before he sets forth upon a year's work. A director of the budget of the United States Government is quoted as follows in Chapman's "Hospital Organization and Operation," p. 46:

"A budget system is nothing more or less than an orderly procedure which requires a constant application of the best known principles of business conduct in the financial affairs of an activity, with the accompanying requisite of a continuous endeavor to keep these activities alive in the acts of the individuals charged with the operation of the system."

Budgeting is by no means a recent development in the business field. All money-making organizations of any magnitude have found such a process necessary for the insurance of annual profits. Hospitals of the accepted type are not expected to pay stock dividends. Their output has been and should still be judged in the light of human dividends of life and health. Perhaps this latter principle has been the cause of the failure of hundreds of hospitals to adopt sound financial policies until many years after their wisdom has been demonstrated in the commercial field.

This reluctance upon the part of hospitals has doubtless deterred their progress. It is a fallacy to suppose that the altruistic aim of the hospital

can be other than promoted by the wise application of proper business methods.

Ten years ago the number of private (as opposed to governmentally owned) hospitals operating under a bona fide budget system was probably less than twenty. Today that figure has been multiplied many times over, largely due to the efforts of certain individuals, particularly the mem-

bers of the committee on forms and records* of the American Hospital Association. Business men on hospital boards and connected with community chests have urged hospitals in their financial operations to come within the pale of good business. No figures are available, but it seems safe to estimate that even now less than half of the private hospitals of the country operate under any semblance of a budget plan. This is a grave error.

This lack of system is, no doubt, one of the contributing causes of the almost constant financial difficulties of

hospitals and may partially explain the failure of so many hospital administrators to succeed in their chosen profession.

Enumeration of all of the benefits to be derived from a proper budget system would require too much space. The most outstanding points are outlined in the following paragraphs:

1. Financial: One of the most tangible results of budgeting is the possibility of thereby promoting wise economy and reducing expenses. How? Because the budget requires attention to the small details entering into expense. It requires its participants to plan a year ahead in place of from day to day; it requires a periodic review of financial performance with its inevitable

Suggestions for Reading

Reports of the committee on forms and records of the American Hospital Association, past five years.

"Hospital Organization and Operation," Frank E. Chapman, pages 29-55.

"Budgetary Control of Hospital Finance," R. N. Brough, THE MODERN HOSPITAL, May, 1925, and June, 1925.

"Better Management of the Hospital Through Budget Control," G. W. Curtis, THE MODERN HOSPITAL, April, 1924.

"Budgeting the Equipment Expenditures of the New Hospital," THE MODERN HOSPITAL YEAR BOOK, Fifth Edition, 1925.

"Accounting and Budget Control in Hospitals," THE MODERN HOSPITAL YEAR BOOK, Fifth Edition, 1925.

*Reports of the committee on forms and records, American Hospital Association, past five years.

lessons as to ways to economize; it provides cost comparisons from month to month and from year to year. In short, it enables and forces the hospital worker to face squarely and certainly the financial results of his efforts.

2. Advantage to the patient: A hospital operated under a budget is almost certain to be more efficient. The patient benefits thereby. The budget will enable the hospital to operate more economically, thus enabling the patient to get more for his money.

3. The trustee finds his position more tenable. He need not live in fear of a sad financial story at the end of the year. There can be no sad story because the cost of operation has been determined by the trustees at the beginning of the year and has been based upon dependable income estimates. If the trustees have budgeted beyond the hospital's estimated income, they have, in effect, pledged themselves to raise the difference and have had a whole year in which to do it. Moreover, the trustee will feel that his contributions or those which he secures will be wisely and economically expended.

4. The superintendent's position is more desirable under a budget plan. He is able before each fiscal year begins, to present to his trustees his recommendations in full for program and policy of the hospital. He is able to secure one decision covering the whole plan rather than piece-

meal consideration. He may operate his institution according to a sound plan, which has continuity in place of the hand to mouth regime so frequently followed.

5. The department head benefits by knowing at the beginning of the year exactly what is expected of his department and how much money he is to have for his work. The financial operations of the hospital are no longer a mystery over which he has no control but for whose failure he is likely to be blamed. He knows, at least once a month, just where he stands and is able to compare his own financial performance with the other departments or with previous records of his own department. He realizes that he has, in effect, been "taken into the firm" and that he plays an important role in the success and progress of the hospital. Seldom will he fail to assume his share of the load. If he fails, he cannot say he was not forewarned. The comparison of the budget efficiency of the various departments arouses his pride and spurs him on to greater effort. His realization of what is expected of him is inevitably translated into efficiency among his subordinates.

Arguments Against Budgets

Some of the main arguments used by the laggards who have failed to grasp the opportunities offered by budgeting are that it is impossible to forecast what the hospital's financial needs will

GRASSLANDS HOSPITAL
Recapitulation—Budget and Expense
Month of May, 1927, and 5 Months Ended May 31, 1927

	1927 Annual Budget	Budget 1 Month	Expense May, 1927	Increase or Decrease 1 Mo.	Budget 5 Mos.	Expense 5 Mos.	Increase or Decrease 5 Mos.
Administrative	38,962.30	3,246.84	3,388.71	I -141.87	16,234.20	16,350.67	I - 116.47
Medical	24,129.00	2,010.74	2,241.12	I -230.38	10,053.70	10,972.35	I - 918.65
Clothing	6,000.00	500.00		D-500.00	2,500.00	2,056.51	D- 443.49
Dietary	101,288.20	8,440.72	7,760.57	D-680.15	42,203.60	38,303.95	D-3,899.65
Special Diets	90,912.90	7,576.06	7,083.85	D-492.21	37,880.30	34,016.45	D-3,863.85
Housekeeping	32,980.20	2,748.34	2,375.85	D-372.49	13,741.70	12,742.51	D- 999.19
Laboratory	14,450.50	1,204.20	1,513.70	I -309.50	6,021.00	6,058.36	I - 37.36
Nursing	100,300.00	8,358.33	8,313.06	D- 45.27	41,791.65	40,189.51	D-1,602.14
Pharmacy	7,497.00	624.75	669.17	I - 44.42	3,123.75	3,738.63	I - 614.88
X-ray	4,989.55	415.79	349.32	D- 66.47	2,078.95	3,100.97	I -1,022.02
Electrocardiograph	320.00	26.66		D- 26.66	133.30		D- 133.30
Occupational Therapy ..	3,013.00	251.07	243.36	D- 7.71	1,255.35	1,312.34	I - 56.99
Recreational	500.00	41.65	108.00	I - 66.35	208.25	140.85	D- 67.40
Educational	3,579.17	298.24	266.66	D- 31.58	1,491.20	1,412.98	D- 78.22
Structures	17,255.00	1,437.90	800.40	D-637.50	7,189.50	6,323.28	D- 866.22
Dental	1,150.00	95.82	182.11	I - 86.29	479.10	536.59	I - 57.49
Sewing Room	1,800.00	150.00	1.03	D-148.97	750.00	241.31	D- 508.69
Professional Services ...	12,100.00	1,008.32	1,006.82	D- 1.50	5,041.60	4,892.88	D- 148.72
Elmwood Hall (Sal.) ..	6,367.50	530.62	506.50	D- 24.12	2,653.10	2,545.08	D- 108.02
Nurses Home	10,100.00	841.66	601.26	D-240.40	4,208.30	1,856.95	D-2,351.35
Nurses Training School .	9,135.00	761.25	125.00	D-636.25	3,806.25	625.00	D-3,181.25
Medical Records (Sal.) .	2,531.25	210.94	241.66	I - 30.72	1,054.70	1,208.30	I - 153.60
Ambulance (Sal.)	3,140.00	261.66	250.00	D- 11.66	1,308.30	1,242.03	D- 66.27
Social Service (Sal.) ..	3,087.50	257.27	258.32	I - 1.05	1,286.35	1,279.12	D- 7.23
Receiving Room (Sal.) .	3,200.00	266.66	290.00	I - 23.34	1,333.30	1,427.50	I - 94.20
TOTALS	498,788.07	41,565.49	38,576.47	D-2,989.02	207,827.45	192,574.12	D-15,253.33

GRASSLANDS HOSPITAL
Comparative Budget and Expense (Details)
Month of May, 1927, and 5 Months Ended May 31, 1927

	1927 Annual Budget	Budget 1 Month	Expense May, 1927	Increase or Decrease 1 Mo.	Budget 5 Mos.	Expense 5 Mos.	Increase or Decrease 5 Mos.
ADMINISTRATIVE							
Salaries	31,211.05	2,600.92	2,543.67	D- 57.25	13,004.60	12,718.43	D- 286.17
Temporary Employees ..	300.00	25.00	.....	D- 25.00	125.00	35.00	D- 90.00
New Equipment	836.25	69.68	16.00	D- 53.68	348.40	530.25	I- 181.85
Maintenance and Repairs	15.00	1.25	.....	D- 1.25	6.25	31.33	I- 25.08
Traveling Expense	1,300.00	108.33	351.24	I-242.91	541.65	594.58	I- 52.93
Office Expense	5,300.00	441.66	477.80	I- 36.14	2,208.30	2,441.08	I- 232.78
TOTALS	38,962.30	3,246.84	3,388.71	I-141.87	16,234.20	16,350.67	I- 116.47
MEDICAL							
Salaries	15,400.00	1,283.33	1,083.32	D-200.01	6,416.65	5,566.60	D- 850.05
New Equipment	2,229.00	185.75	478.50	I-292.75	928.75	2,468.25	I-1,539.50
Maintenance and Repairs.	1,000.00	83.33	81.57	D- 1.76	416.65	245.24	D- 171.41
Supplies and Materials..	5,500.00	458.33	597.73	I-139.40	2,291.65	2,692.26	I- 400.61
TOTALS	24,129.00	2,010.74	2,241.12	I-230.38	10,053.70	10,972.35	I- 918.65
CLOTHING							
Supplies and Materials..	6,000.00	500.00	.....	D-500.00	2,500.00	2,056.51	D- 443.49
DIETARY							
Salaries	31,380.00	2,615.00	2,535.32	D- 79.68	13,075.00	12,465.80	D- 609.20
New Equipment	1,515.00	126.25	100.00	D- 26.25	631.25	1,359.50	I- 728.25
Maintenance and Repairs.	2,280.00	190.00	49.20	D-140.80	950.00	738.17	D- 211.83
Supplies and Materials ..	785.00	65.45	39.90	D- 25.55	327.25	309.56	D- 17.69
Food	65,328.20	5,444.02	5,036.15	D-407.87	27,220.10	23,430.92	D-3,789.18
TOTALS	101,288.20	8,440.72	7,760.57	D-680.15	42,203.60	38,303.95	D-3,899.65

be; that it is impractical to make a budget because the hospital's income fluctuates too greatly; that cost accounting system and detailed financial reports so increase the cost as to neutralize any advantage to be gained from the budget.

None of the above points are defensible.

If a hospital is new it has the experience of other similar institutions to draw upon. The expense can always be estimated. The budget is safe if kept near the minimum.

If the income fluctuates, the budget may be made at the minimum of expectancy.

Business, big and small, has disproved the arguments stated. Cost accounting and issuance of reports will always be possible. In small institutions this requires small effort and little time. It will cost no more than ordinary bookkeeping. Moreover the mere act of preparing a budget has excellent effect upon efficiency and economy.

Most of the alleged disadvantages of the employment of budgets lie in the mental lethargy of the trustee or superintendent who taboos them.

Information Needed for Budget Making

Intelligent formulation of a budget for any hospital requires close attention to many facts and influences.

Any institution as well as any business will be likely to fail unless its activities are carefully planned. The first requisite in budget making is that the trustees or superintendent, or both,

formulate a set of aims and undertakings. These may undergo development over many years. It goes without saying that to be intelligently made, a budget must have a goal at which to aim. It must be agreed before the budget is made what the budget is supposed to accomplish. How much free work shall be done? Shall the institution's activities be decreased or increased? Does the institution need to be improved? If so, in what respects? Are any new departments to be added?

The persons concerned with making a budget must ascertain:

1. Past financial performance of the institution. If a budget plan has been employed in past years, this information is readily available and is invaluable. If the hospital is preparing its first budget it nevertheless will have financial statements of some sort for past years which will be most helpful, unless it be a new institution. In the latter event it may always draw upon the experience of others. The first year's budget of a new hospital is admittedly difficult to make, but Chapman* and others agree with the author that it is better to make a budget for the first year, risking inaccuracy, than to wait for accumulation of a year's experience before introducing the plan.

2. Price trends, past, present and probable future. Such facts must, of course, be taken into

*Hospital Organization and Operation, F. E. Chapman, pages 29-55. The Macmillan Company, New York.

consideration. A capable superintendent and steward can make a fairly accurate forecast. This was evidenced by the successful way in which certain hospitals met the unprecedented post-war inflation period.

3. Probable growth or shrinkage in the work. Changes in bed capacity, addition of new departments or of new functions to existing departments must all have consideration. It is well for all departments before they submit their budgets, to be given a forecast as to the probable number of ward and private room days of service, the average number of employees, and such other data as can be prepared. The department head must, of course, have careful financial reports of his own department's past performance.

4. Special needs. It is well for the superintendent and every department head to have a file heading of "Budget Reminders," so that as needs present themselves during the year, they may be recorded for consideration at budget-making time. This is particularly valuable in relation to items of new equipment or replacements of equipment.

How to Compute a Budget

As the hospital is departmentalized for the betterment of its administration and for proper division of labor, so should the preparation of the budget follow departmental lines. The department head who makes his own budget feels greater responsibility for its success. The planning of the budget should be constantly in mind during the year. The actual presentation of departmental requests should not be too long delayed. Some institutions with fiscal years ending December thirty-first, start their budget-making as early as July or August. Perhaps this is too early, as it is not possible to know enough about the current year's performance to give accurate data. It seems certain, however, that the month of October should see the budget in process of preparation.

The superintendent should notify each department head as to the date for presentation to him of budgets. In the same memorandum he should outline clearly the projected volume of work, as well as any proposed alteration of procedure. He should provide each department head with all of the useful data accumulated through past reports. The department head should present his budget to the superintendent, giving details and reasons for requests.

Departmental budgets can often be subdivided into (a) salaries; (b) supplies and materials; (c) replacements of equipment; (d) new equipment. Items (a), (c), and (d) should be itemized. Item (b) may be itemized in certain cases.

Having received the budget requests of the department heads, the superintendent should study them. He must decide upon the total amount of the budget and determine the relation between this amount and the total of the departmental requests. He should then hold a series of budget "hearings" giving each department head the opportunity of explaining his requests. If alteration or cutting of the departmental budget seems necessary, he should discuss this with the department head and consult him as to which items or accounts may be reduced with the minimum injury to production and efficiency. This is a wise procedure and is greatly appreciated by the department head. Needless to say, most departmental budgets have to be cut, although, occasionally the superintendent may wish to add rather than subtract.

The departmental budgets having been determined and assembled into a hospital budget, the superintendent should seek a hearing with the finance committee of the board of trustees. He should present the budget to them, and with it an accurate estimate of the income for the budget period.

The finance committee should study the income schedule and the budget, and if cutting is necessary should consult the superintendent as to the parts that may be cut with the least injury to the work. The finance committee will then present the budget to the board for adoption. Accompanying the budget the finance committee should present an income estimate, with a request that the board make provision at once for any increase of budget total over estimated income.

The budget having been passed, several certified copies should be prepared, one each for the superintendent, the steward, the bookkeeper, the president of the board, the executive committee and the finance committee. The superintendent should then send to each department head a copy of the final appropriations made for his department.

How to Control Operation of Budget

It requires great care to prepare a budget, but still greater care is necessary in the actual administration and carrying out of its provisions. Institutions that must depend upon their monthly income to meet their bills, will find it necessary rigidly to adhere to a monthly schedule, not permitting more than one-twelfth of the year's budget to be spent each month. Occasional exceptions may be made where expensive items of equipment are badly needed, but it is better to wait until sufficient funds have accumulated before making such purchases.

Public hospitals operating under appropriations that do not depend upon monthly income are inclined to purchase items of new equipment and replacements of equipment that have been allowed and are definitely needed, early in the year. While this plan disturbs slightly the even functioning of the budget, there appears to be no good reason why the institution should wait until later in the year, inasmuch as the money is already appropriated and available. From the viewpoint of the governmental unit as a whole, of course, the longer the public funds may be kept at interest the better.

A secret of successful budget administration is extreme efficiency in compilation of monthly budget reports. For a large hospital the monthly budget report will usually include from four to eight pages of figures. Inasmuch as these reports should go to members of the board of trustees and to all department heads, it is usually desirable to issue the report in mimeographed form. It is a mistake to economize by making only a few typewritten copies. Good budget practice requires that the ultimate spender see the financial results of his work. If there are enough reports for general distribution this aim will be accomplished.

The form of report recommended by the committee on forms and records of the American Hospital Association is desirable. There is here reproduced a specimen first-page summary of a budget report for the month of May, and also a specimen page of the detailed portion of the budget. (See pages 94 and 95).

Department heads should have access to the bookkeeping department, in case they wish to look up further details concerning the amounts charged against their funds. It seems unwise to print individual salaries or other confidential figures, which there is no good reason for divulging.

In order to keep the budget strictly up to date, it is necessary that vouchers be made out as soon as goods are delivered, and that the account be charged with the appropriate amount whether or not the bill has actually been paid, the receiving slip from the department head being sufficient authorization for allocation of charge.

The superintendent should call a department head meeting soon after the monthly report has appeared; should talk over frankly with his department heads the institution's financial condition; should compliment the departments showing good budget records, and ask for explanations from those whose budgets have been overdrawn. Above all, the superintendent or other person approving requisitions should have the latest budget report constantly before him and should consult it before approving further expenditures. It is a valuable practice to show on each order sent for approval the condition of the budget account in question. Budget performance should be used by the superintendent as a definite measuring rod of the success of his department heads. He will, of course, use other means than this of judging the individual, but he should make it known that any department head who fails to live within his budget cannot be considered entirely successful. He must also constantly remind all concerned that economy further than that required by the budget is always desirable.

Factors in Budget Success

The question is often raised as to whether the hospital's budget should take into consideration possible emergencies that may arise within the hospital, or possible epidemics and accidents in the community that may cause the hospital greatly to increase its expense. It seems unwise, in principle, to add anything to the budget to

Review Work

1. Compute the probable annual income of some hospital known to you.
2. Why are a perpetual inventory and a cost accounting system necessary to the administration of a budget?
3. What can you say as to the amount of detail that a budget should include?
4. What is the advantage of holding hearings with department heads before cutting or other alteration of budgets?
5. Give reasons why, in your opinion, the food expenditures of a dietary department should fluctuate more than is usual with accounts in other departments of the hospital.
6. Supposing you, as superintendent, were confronted with a serious overdraft in the account for pharmacy supplies, what investigations would you make and what other steps would you take in the matter?
7. Supposing you, as superintendent, were confronted with a serious overdraft in the account for electric light and power, what investigations would you make and what other steps would you take in the matter?

cover expense that is improbable. Should an emergency occur, the hospital can almost invariably depend upon sufficient local support to tide it over. Hospitals meet small emergencies almost daily. An overdraft in one department is likely to be neutralized by an underdraft in another. An emergency fund is also advised against, inasmuch as it might offer undue temptation to all concerned to be careless in expenditures, knowing that funds in addition to the budget were actually available.

Hospitals that have made careful budgets seldom have any unexpended balances at the end of the year, of any great moment. The question may logically arise, however, as to what may be done with unexpended balances in case they occur. The obvious answer would be to apply this balance toward the next year's budget. Some hospital boards might prefer to apply the balance to the endowment or to capital accounts. Hospitals entirely supported by the income from patients would probably consider reducing the rates for patients for the coming year.

Specific Salary Grants Made

In many public institutions it is legally required that the full amount of salary for every position in the hospital be appropriated in the annual budget. It is obvious that such a situation causes a balance to accumulate in the salary account, because of vacant positions and positions filled at less than the established scale. In large institutions with considerable labor turnover, this accrual amounts to thousands of dollars in the course of a year. It is the custom of some public hospitals to request permission from their appropriating bodies to use such salary accrual funds for the purchase of articles that would otherwise be included in the next budget. This procedure really makes no difference in the ultimate cost to the taxpayer, but does enable the hospital to make full use of the amount of money appropriated to it. The budget appropriations are always closely scrutinized by the taxpayers, and they fail to give credit in case money is turned in at the end of the year.

Some institutions provide financial incentive for economical management to their department heads. A bonus system is considered desirable by some.

The administration of the budget is promoted if allocation of charges to departments is promptly made and if the report, when it comes out, can be as nearly as possible up to date.

It is particularly undesirable to charge to the first month of a fiscal year, materials that were actually received and used in the last month of

the previous fiscal year. The new budget should not be penalized by any carry-over from the previous year. A budget properly handled enables the superintendent and his staff to work "in the light of day" in financial matters. There need be no guess work or uncertainty. They do not need to "hope" that the books will balance at the end of the year. The monthly analyses will have warned them promptly of danger ahead and, having been forewarned, they are able to prevent financial catastrophe.

HOSPITAL ADMINISTRATION IN NEW ZEALAND

The New Zealand Health Act, 1920 (repealing the Public Health Act, 1908) provides for the establishment of a department of state, called the department of health under the control of a minister of the crown, called the minister of health. The chief administrative officer is the director-general of health. The department comprises the division of public hygiene, hospitals, nursing, dental hygiene, school hygiene, child welfare and maori hygiene, each of which is under the supervision of the divisional head called the director.

One of the functions of the department is the "organization and control of medical, dental and nursing services, so far as such services are paid for out of public moneys, not being services in connection with any institution established under the Mental Defectives Act, 1914." Under this regulation the department has provided seven maternity hospitals, two tuberculosis hospitals and four other special hospitals. The department steps in and provides such hospitals to meet a special need in the hospital service of the country that has not been otherwise provided for, and controls the same until the opportunity is presented for the hospital boards to take such institutions over. The department does not desire to run a hospital service of its own independent of the hospital boards.

Local Bodies Made Responsible

The main responsibility for providing and administering hospitals was placed by the Hospital and Charitable Institutions Act, 1909, on local bodies called hospital boards. Hospital boards are elected on the adult franchise every two years, on the same day that the municipal and county elections take place. There are forty-four hospital boards controlling seventy-four general hospitals, three chronic hospitals, four infectious disease hospitals, five sanatoriums for tuberculosis, one sanatorium for general cases, and seven maternity hospitals. The seventy-four general hospitals had 5307 beds in 1923 of which the average number occupied daily was 3,586. (This is exclusive of the other institutions mentioned belonging to the hospital boards and the government.)

The average annual cost of maintaining a general hospital bed was 184.5 pounds sterling, which is \$2.25 a day. The maintenance charge is nine shillings per day or about \$2 a day.

There are too many controlling hospital boards in New Zealand, a circumstance tending to nullify the efficiency of the entire hospital system. Hospital boards are also the charitable aid authorities and provide outdoor relief and custodial care in institutions separate from the general hospital.—Dr. A. R. Falconer, resident medical superintendent, Dunedin Hospital, Dunedin, New Zealand.

NEWS OF THE MONTH

COMMONWEALTH FUND PLANS THIRD OF SERIES OF RURAL HOSPITALS

Farmington, Maine, a town of 3,200 inhabitants in the Rangeley Lake region, will receive approximately \$140,000 from the Commonwealth Fund, New York, toward the construction of a modern hospital, according to an announcement made at the headquarters of the Fund.

This is the third of a series of rural hospitals planned under a cooperative program, which contemplates the building of two such institutions annually in selected communities throughout the United States, with the object of improving health and the conditions of medical practice in country districts.

As with the other communities accepting the terms of these grants, Farmington will contribute a third of the cost and will assume the operating expenses, while the Commonwealth Fund will donate the remainder of the capital cost and will provide plans and specifications for a fifty-bed hospital meeting the highest modern standards of construction and equipment.

Fourteen communities in eight states made formal application for the third institution offered under the Fund's rural hospital program, and Farmington was chosen after thorough study of the local needs of these towns.

Two southern communities, Farmville, Va., and Glasgow, Ky., were selected for the hospitals to be built under last year's appropriation, and accordingly northern and mid-western states were given preference in the selection of the third site.

HOSPITALIZATION PROJECTS FOR CHICAGO OUTLINED

In connection with the dedication ceremonies of the Montgomery Ward Memorial Building of the Northwestern University Medical School, Chicago, tentative plans were outlined for a \$15,000,000 program of construction and operation by the university of three hospitals and a nurses' home. The scheme proposed is for a general university hospital to cost \$3,000,000 and contain 300 beds; a maternity hospital to cost \$2,400,000, providing 200 beds; a children's hospital to cost \$1,500,000 for 125 patients and a nurses' home.

A campaign for funds for the scheme will soon be started, it is expected. It was also stated that negotiations are under way between the American College of Surgeons and the university for construction of an industrial hospital in the vicinity.

TORONTO GENERAL HOSPITAL TO BENEFIT

The board of governors of the Toronto General Hospital, Toronto, Ontario, has announced a gift of \$25,000 toward its building fund, from the Canadian Pacific Railway. The donation was made because of the belief that the new hospital would benefit not only Toronto but the entire province.

BRITISH HOSPITALS ASSOCIATION MEETS AT NORWICH

The seventeenth annual meeting and conference of the British Hospitals Association was held at Norwich, England, June 23 and 24, under the chairmanship of the Hon. Sir Arthur Stanley, G.B.E., C.B., M.V.O., the president of the association.

There was an attendance of about one hundred and twenty delegates who were formally welcomed by the Right Hon. the Lord Mayor of Norwich.

The morning session on June 23 was devoted principally to the presentation of a paper on "The Function of the Voluntary Hospitals in Relation to the Public Health Services," by Sir Arthur Stanley. In this paper it was pointed out that the time has come when the voluntary hospitals should consider their relations to the public health services and determine for themselves what functions they can best perform. The social medium in which the voluntary hospitals now work has changed in character and the hospitals have outgrown in some measure their former scope, while taking on additional work in other directions. These institutions from being merely dispensers of charity have become the main centers of training and research. Sir Arthur emphasized the lack of cooperation noticeable between the voluntary hospitals themselves which is a handicap in reaching any decision as to the relationships that should exist between the voluntary hospitals and the State and public authorities. He outlined a number of questions that must be given deep thought before any scheme for the coordination of hospitals and medical services can be established.

At the afternoon session W. J. Jenkins, London, discussed the subject of "Motor Accident Cases in Hospitals from the Insurance Point of View." The question of compensation to hospitals for treatment of street accident cases has been a problem urgently demanding solution for some time. Mr. Jenkins said that it is the practice of insurance companies to call for proof that medical expenses have been incurred before reimbursing their assured, and when an amount is claimed for maintenance whilst in the hospital and medical expense incurred therein, such items are not paid until the insurance company is satisfied that the hospitals have been paid or will be paid by the injured person. He also pointed out, however, that so long as the underlying principle of the administration of the hospitals is a voluntary one, it does not seem practicable to enforce payment for maintenance or for services rendered in accident cases.

Spirited discussion, taken part in by many of those present, followed the reading of the papers.

On June 24 a business meeting was held, followed by a round table conference on the "Pensions Scheme for Hospital Officers and Nurses," conducted by Sir Edward Penton, K.B.E. The work that has been done during the past year in organizing the scheme was thoroughly discussed, and the benefits which it offers to hospital officers and nurses were enlarged upon. It was stated that it is not yet possible to fix a definite date for launching the scheme, but it is hoped that it will be in operation soon.

News of the Month

REAL HOME IS GIFT TO NURSES OF JOHNSON CITY

A new nurses' home for Johnson City General Hospital, Johnson City, N. Y., has been erected at a cost of \$200,000, and was formally opened in May.

The building is three stories high in front and four stories in the rear, including a daylight basement. It contains eighty-five sleeping rooms. The wings form a court at the rear of the center part of the building, designed like a Spanish patio, with flower beds and tables and easy chairs. All rooms have outside windows and the bedrooms are nine and a half by eleven and a half feet in size. Their walls are tinted in cream color and all-steel furniture is used. Each room has a steel wardrobe or closet and each bed has a bed lamp with shade to match the furnishings.

The building is the gift of C. Fred Johnson, Johnson City, N. Y., and is dedicated to the memory of Mrs. Ida F. Johnson, whose portrait is hung over the fireplace in the main lobby.

COURSE IN DIAGNOSIS OFFERED

The board of trustees of the Mississippi State Sanatorium, Sanatorium, Miss., is offering a course in diagnosis of diseases of the chest, to be given at that institution for the benefit of physicians of the state. Some counties have made arrangements for their health officers to avail themselves of this opportunity.

ALL OUTSIDE ROOMS IS FEATURE OF HOSPITAL FOR NEGROES

The L. Richardson Memorial Hospital for negroes, Greensboro, N. C., was recently formally dedicated and thrown open for service. Dr. W. S. Rankin, director, The Duke Endowment, Charlotte, N. C., was one of the speakers at the opening ceremony and stated that the Duke Hospital Board will aid in defraying the expenses of maintaining the new hospital. One dollar will be given each day for every bed maintained for charitable purposes. This will amount to approximately \$10,000 each year.

The new structure is fireproof and is modernly equipped. It is of the Spanish Mission type of architecture and cost about \$150,000, \$50,000 of which was given by the family of the late L. Richardson as a memorial to him. Every room in the hospital is an outside room and numerous windows admit abundant sunshine and fresh air.

PENNSYLVANIA SPONSORS T. B. MOBILE CLINICS

Diagnostic extension tuberculosis mobile clinics will be carried on during the spring, summer and early fall by the Pennsylvania State Health Department, according to the *Atlantic Medical Journal*. The work will be under the general supervision of Dr. W. G. Turnbull, deputy secretary of health, Harrisburg, Pa. Dr. C. C. Custer, assistant superintendent, Mont Alto Sanatorium,

will be the field supervisor. Activities have already started in Union County.

Similar work was carried on last fall and it was found that a definite need for this type of service existed. According to Dr. Turnbull a letter has been written to local physicians indicating that these activities are for the benefit of Pennsylvania's population in localities where regular state clinics do not exist. They are for diagnosis only, as a copy of the findings and recommendations is referred to the local physicians for action. The units will not treat any cases.

SHRINERS AID CRIPPLED CHILDREN

The hospital movement of the Shriners of North America is a little over four years old and is now responsible for fifteen hospitals in the United States and Canada, devoted to the care of crippled children. The latest addition to these specialized institutions was opened in June, at Greenville, S. C.

There is no barrier of race, color or creed for admission to these hospitals, and all that is necessary is that application for admission be first made to a Shriner. Hopeless cases are not taken and usually those over fourteen years of age cannot be helped to any great extent. The average stay of a child is around sixty-five days, and as soon as one bed is emptied another patient is put in, there being a waiting list that exceeds the available accommodations.

The hospital treatment costs the child's parents nothing. An assessment of \$2 a year is laid on every Shriner in the country for the support of these hospitals. This money and voluntary contributions constitute the means whereby thousands of children are aided and often cured.

HOSPITAL ANNOUNCES BUILDING PROGRAM

Announcement has been made by the Cottage Hospital, Santa Barbara, Calif., of plans for the immediate building of four new units at a cost of \$225,000. A new three-story wing will be added to the main building and a new wing to the nurses' home, and other reconstruction work will be carried out.

NEW TEACHING HOSPITAL ADDED TO UNIVERSITY OF PENNSYLVANIA

Construction of the new \$2,000,000 teaching hospital for the graduate school of medicine of the University of Pennsylvania, Philadelphia, is well under way. The new building will be twelve stories in height, surmounted by a two-story tower. It will have a capacity of 500 beds and will provide for 175,000 out-patients a year. All medical and surgical cases will be treated but no provision is being made for chronic, contagious or mental cases.

The new hospital building will be used in connection with the Polyclinic Hospital buildings adjoining it which have been remodeled. It will form the central unit of the graduate school of medicine of the University of Pennsylvania.

News of the Month

H. H. GRAEF has been appointed superintendent of the Children's Hospital, Akron, Ohio, to succeed ARTHUR C. BAUSS, resigned. MR. GRAEF formerly had charge of a hospital in an industrial plant.

KATHERINE B. ST. GERMAINE, superintendent of Bide-A-Wee, the hospital for contagious diseases at Watertown, N. Y., has resigned after five years of service in that position. Her successor has not yet been chosen.

MRS. GERTRUDE WARD was recently appointed superintendent of the Erie County Tuberculosis Hospital, Erie, Pa.

DR. RAYMOND F. C. KIEB has been appointed State Commissioner of Correction of New York by Governor Smith. DR. KIEB has been associated with state work for over twenty years and has been medical superintendent of Matteawan State Hospital, Beacon, N. Y., for the past thirteen years.

DR. F. G. EDWARDS is the new superintendent of the Kula Sanitarium, Waiakoa, Hawaii.

DR. EDGAR A. PATTON has resigned the position of medical director of the Pressmen and Assistants' Union Sanitarium, Pressman's Home, Tenn., to accept the directorship of the Beverly Hills Sanatorium, Knoxville, Tenn. DR. PATTON will be succeeded by DR. JAMES S. LYONS.

SIDNEY LEFF has been appointed superintendent of the Brownsville and East New York Hospital, Brooklyn, N. Y.

DAVID PENDER was recently elected president of the Norfolk Protestant Hospital, Norfolk, Va., succeeding JAMES B. MOSS who resigned because of press of business which made it impossible for him to give his time to the hospital's work.

HELEN S. TEEPLE was recently appointed superintendent of Dr. Richard's Private Hospital, Port Deposit, Md.

FRANK D. KING, formerly city clerk and purchasing agent of Flint, Mich., has been appointed superintendent of the Hurley Hospital in that city.

DR. G. J. PETTIT has taken charge of the State Tuberculosis Sanitarium, Hopemont, W. Va., as temporary superintendent. DR. M. D. CURE, former superintendent, has resumed his practice of medicine.

DR. J. P. RUNYAN has resigned the superintendency of the Baptist State Hospital, Little Rock, Ark. I. E. TAYLOR, field secretary of the state Baptist laymen's organization, will serve as temporary superintendent until an appointment is made by the committee appointed for the purpose.

DR. KARL M. BECK was recently appointed superintendent of the Lake County General Hospital, Waukegan, Ill. He succeeds DR. CHARLES LIEBER who has held the position for the past five years.

DR. R. W. DUNHAM recently resigned as medical director of the Oak Forest Tuberculosis Sanitarium, Oak Forest, Ill. He has accepted a similar position at the Ottawa Tuberculosis Sanitarium, Ottawa, Ill.

R. J. FOX has been appointed superintendent of the new Delaware County Hospital which was recently opened at Upper Darby, Pa.

DR. ROBERT BELL was recently appointed superintendent of the Outlook Tuberculosis Sanitarium, Urbana, Ill.

MRS. A. L. WILSON was recently appointed superintendent of the Robert B. Green Memorial Hospital, San Antonio, Tex., succeeding MRS. MARTHA P. ROBERTSON who resigned to accept the superintendency of the Medical and Surgical Clinic in the same city. MRS. WILSON was formerly superintendent of the Woodmen of the World Memorial Hospital, San Antonio.

DR. W. J. BRYAN recently resigned the superintendency of the Missouri State Sanatorium, Mount Vernon, Mo. He is at present taking post-graduate work in tuberculosis preparatory to assuming the superintendency of a sanatorium in New Jersey next November.

JOE F. MILLER has recently resigned the superintendency of the Methodist Hospital of Central Illinois, Peoria, Ill., a position which he has held for several years.

MRS. EDNA L. HUSTED is the new superintendent of the City Hospital, Altus, Okla., succeeding SADIE MANSFIELD who recently resigned.

CLARA A. FISHER was recently appointed superintendent of the Ashtabula General Hospital, Ashtabula, Ohio. MISS FISHER formerly held the position of superintendent of the Jewish Hospital, Louisville, Ky.

AGNES MACNEIL recently accepted the superintendency of the Ashland General Hospital, Ashland, Wis. MISS MACNEIL had been associated with a New York City hospital previous to going to Ashland.

MAE E. HEINMILLER, R.N., recently resigned the superintendency of the Monnett Memorial Hospital, Bucyrus, Ohio. The new superintendent is JESSIE BUMFORD.

DR. LEE E. GRISCOM has been appointed director of the new Marion Childs Hospital for Children, a unit of the West Jersey Homeopathic Hospital, Camden, N. J. DR. GRISCOM has been on the staff of the West Jersey Hospital for several years and has specialized in pediatrics for some time.

F. STANLEY HOW, formerly assistant business manager of the Rockefeller Institute for Medical Research, New York City, has recently been appointed director of the Orange Memorial Hospital, Orange, N. J.

CARMELITA A. LAGLAND has been selected to take charge of the American Hospital at Guatemala City, Central America, for three years. MISS LAGLAND is a graduate nurse of Mary's Help Hospital, San Francisco, Calif.

LEROY MILLER has recently been appointed superintendent of the Municipal Tuberculosis Sanitarium, Chicago.

DR. J. J. GOLUB has resumed his duties as superintendent of Beth Moses Hospital, Brooklyn, N. Y., having served as assistant to DR. S. S. GOLDWATER, director, Mount Sinai Hospital, New York City, for some time.

News of the Month

CHILDREN'S HOSPITAL ASSOCIATION TO MEET WITH A. H. A.

The Children's Hospital Association of America will hold its annual meeting October 12 and 13, at Minneapolis, Minn., in connection with the annual conference of the American Hospital Association.

Interesting topics of discussion appear on the program which is now ready. Among these are "The Relation of the General Practitioner to the Children's Hospital" by Dr. O. W. Rowe, Duluth, Minn.; "Health Teaching in a Children's Hospital" by Mary E. Murphy, director, Elizabeth McCormick Memorial Fund, Chicago; "Organization of the Medical Staff in a Children's Hospital" by Dr. Isaac A. Abt, professor of pediatrics, Northwestern University Medical School, Chicago; "The Medical Laboratory in a Children's Hospital" by Dr. M. G. Peterman, Milwaukee Children's Hospital, Milwaukee, Wis.; and "The Out-Patient Service of a Children's Hospital" by Dr. Joseph Brennehan, Children's Memorial Hospital, Chicago. Discussion will follow the presentation of these papers and there will also be a round table discussion on "Architectural Ideas and Essential Requirements in the Construction of a Children's Hospital."

A feature of the meeting will be specially arranged clinics and a trip of inspection to several of the more interesting hospitals in and around Minneapolis.

Robert E. Neff, administrator, James Whitcomb Riley Hospital for Children, Indianapolis, Ind., is the president of the association.

HOSPITAL ADMINISTRATION COURSE AT NEW YORK UNIVERSITY

A course in institutional management is to be given at New York University, New York, this Fall, under the direction of Edgar C. Hayhow, B.C.S., New Rochelle, N. Y., and E. H. Lewinski-Corwin, Ph.D., director, Hospital Information Bureau, New York. Community relationships of hospitals will be one of the important topics taken up at this course and there will be discussion of the numerous social and economic questions that have a bearing on the problem of disease and, in particular, that aspect of it that has relationship to the hospital's out-patient department.

Some of the specific subjects to be covered are: economic and financial problems of hospitals; hospital supply and demand; the relationship of public health agencies to hospital dispensaries and health centers; the relation of the convalescent home to the whole field of public health and hospitals; hospital publicity and the writing of annual reports and the relation of hospitals to the training of physicians, nurses, social workers and technicians of various kinds.

HUNTINGTON WILL LEAVES \$2,000,000 FOR HOSPITAL

By the will of the late Henry E. Huntington, San Marino, Calif., financier and art collector, \$2,000,000 is bequeathed for a memorial hospital to be built in Los Angeles, Calif.

HOSPITALS IN CAROLINAS SHARE IN DUKE ENDOWMENT

The distribution of funds available for hospitals in North and South Carolina for the present year, through the Duke Endowment, is announced. Thirty hospitals in North Carolina and fifteen in South Carolina, none of which "are operated for private gain," participate in this distribution, the total amount available for these forty-five institutions being \$278,038.

MATERNITY HOSPITAL IS REMODELED AND ENLARGED

The Maternity and Children's Hospital, Toledo, Ohio, has recently been completely remodeled and new wings added, increasing the capacity of the institution from seventy-five to 200 beds.

The hospital is equipped to give general service to women and children. Medical and surgical cases in women are cared for on the second floor; the third floor is devoted exclusively to maternity cases, having a fifty-four bed capacity and a large nursery; children's cases will occupy the fourth floor, which has accommodations for fifty cases. A large sun room runs the length of the building on one side, where sun treatments will be given. The roof also will be utilized for heliotherapy. Glass partitions separate the children's rooms and in the wards each bed is separated from the next one by a glass enclosure.

COMING MEETINGS

American College of Surgeons.

President, Dr. W. W. Chipman, Montreal.
Director General, Dr. Franklin H. Martin, 40 East Erie St., Chicago.
Next meeting, Detroit, Mich., October 3-7, 1927.

American Dietetic Association.

President, Florence Smith, St. Mary's Hospital, Rochester, Minn.
Secretary, Quindara Oliver, 25 Marlboro Street, Boston.
Next meeting, St. Louis, Oct. 17-19, 1927.

American Hospital Association.

President, Dr. R. G. Brodrick, University of Stanford Hospitals, San Francisco, Calif.
Executive secretary, Dr. William H. Walsh, 18 East Division Street, Chicago.
Next meeting, Minneapolis, Minn., October 10-14, 1927.

American Occupational Therapy Association.

President, T. B. Kidner, 175 Fifth Avenue, New York.
Secretary-treasurer, Eleanor Clarke Slagle, 175 Fifth Avenue, New York.
Next meeting, Minneapolis, Minn., Oct. 10-14, 1927.

American Protestant Hospital Association.

President, Robert Jolly, Baptist Hospital, Houston, Texas.
Secretary-treasurer, Rev. Frank C. English, Christ Hospital, Cincinnati.
Next meeting, Minneapolis, Minn., October 8-10, 1927.

American Public Health Association.

President, Dr. Charles V. Chapin, Superintendent of Health, Providence, R. I.
Executive Secretary, Homer N. Calver, 370 Seventh Avenue, New York.
Next meeting, Cincinnati, Oct. 17-21, 1927.

Children's Hospital Association of America.

President, Robert E. Neff, Robert W. Long State Hospital, Indianapolis, Ind.
Secretary-treasurer, Bena M. Henderson, Children's Hospital, Milwaukee.
Next meeting, Minneapolis, Minn., Oct. 12-13, 1927.

Oklahoma Hospital Association.

President, Dr. L. E. Emanuel, Chickasha.
Secretary-treasurer, Mrs. E. E. H. Moore, Shawnee City Hospital, Shawnee.
Next meeting, Miami, Nov. 8-9, 1927.

News of the Month

HOSPITAL FOR CURABLE MENTAL CASES IS ESTABLISHED

The Jewish Mental Health Society, New York, is establishing at Hastings-on-Hudson, N. Y., a hospital devoted primarily to the care of mental cases among Jews. This hospital is the first institution of its kind for Jews in this country, according to *Mental Hygiene Bulletin*. As the hospital will be run without any idea of profit, the poor and those in moderate circumstances will be able to secure treatment. For the present only curable mental cases will be received, especially those in the early stages requiring institutional treatment.

The hospital is equipped to care for twenty-five patients. Later it will receive a much larger number and all classes of mental cases, both children and adults. While the hospital is primarily for Jews the institution will be operated on a strictly non-sectarian basis.

HOSPITAL OFFICIALS DISCUSS PROBLEMS

A group of hospital executives from different community hospitals in New York state have formed a permanent organization to discuss problems of hospital administration at conferences held monthly at the various hospitals represented in the group. There will be no permanent officers and the superintendent of the entertaining hospital will act as chairman of the meeting. Dinner is served at the close of the conference. Labor problems, the need for a centralized employment bureau and the perpetual inventory system, were among the subjects covered at a recent meeting. These topics will be discussed in greater detail at succeeding meetings.

Among the hospitals in this progressive group are the Samaritan Hospital, Troy, Albany Hospital, Albany, Memorial Hospital, Albany, Ellis Hospital, Schenectady, Saratoga Hospital, Saratoga, and the St. Peter's Hospital, Albany.

CITY BLOCK BEQUEATHED TO HOSPITAL

About \$4,000,000 for a hospital on Riverside Drive, New York, has been bequeathed to St. Luke's Hospital, New York, by the late Mrs. Mary Ann FitzGerald. Mrs. FitzGerald has given more than a block of property and \$1,500,000 outright to the institution, with the remainder of the bequest to come after the death of trust fund beneficiaries. St. Luke's Hospital must make a written agreement to erect and maintain the hospital as provided for in the will.

SITE DONATED FOR NEW HOSPITAL AT RAHWAY, N. J.

Fred C. Squier, Rahway, N. J., has donated nearly eight acres of ground to be used as a site for the new memorial hospital planned for Rahway, N. J. A campaign is being conducted to raise a sum of \$500,000, one half of which will be used for the erection and equipment of the hospital, the remainder to form a nucleus for a permanent endowment fund. This will be a new home

for the Rahway Hospital, whose name will be changed to the Memorial Hospital, and it is planned that the institution will serve the needs of Woodbridge and Carteret, as well as those of Rahway.

The new building will be a three-story structure, according to the tentative plans drawn by Crow, Lewis & Wick, architects, New York. It will be of brick and fire-resistant, and will contain approximately fifty to sixty rooms. The building will be so constructed as to provide for additional accommodations when needed.

TWO BROOKLYN HOSPITALS TO MERGE

The merger of two of the oldest hospitals in Brooklyn, N. Y., was recently consummated after two years of consideration. James H. Post, president of the Williamsburg Hospital and also president of the Brooklyn Eye and Ear Hospital, has announced that the work of these two institutions will now be carried on under the name of the latter.

The Williamsburg Hospital has been inactive since 1920 and the territory which it covered is adequately cared for by other hospitals in the vicinity. The merger makes possible the erection of a \$1,500,000 building which has been contemplated for some time. The resources of the Williamsburg Hospital as well as the sum received from the sale of the building will be used for the new institution, the clinic of which will be known as the Williamsburg Clinic. The Brooklyn Eye and Ear Hospital has been established for more than sixty years and has accommodated a large number of dispensary cases.

ROYAL ALEXANDRIA REPORTS SURPLUS

A surplus of \$922 for the first four months of this year is reported for the Royal Alexandra Hospital, Edmonton, Alberta, according to financial statements made recently by J. W. Heron, chairman of the finance committee and Dr. H. R. Smith, medical superintendent of the hospital. The hospital has not required any part of the city hospital grant during that period. An increase of 3,800 patient days, compared with the same four months in 1926, was also reported, and an increase of 176 surgical operations.

WINONA HOSPITAL RECORDS PROGRESS

The annual report of the Winona General Hospital, Winona, Minn., for the year ending April, 1927, records unusual growth and increased prosperity of the hospital. Six hundred sixty-two more patients have been cared for than during the preceding twelve months, and 54 per cent of the babies born in Winona during the year were born at the hospital.

The hospital dates back to February, 1894, and has made steady progress, according to the report of Dr. D. B. Pritchard, secretary of the hospital. During the past year changes and improvements have been made in various departments and three stories have been added to the building, giving accommodations for forty-two additional patients.

News of the Month

NASSAU COUNTY'S PREVENTORIUM NOW OCCUPIED

Nassau County's new preventorium for children is now fully equipped and occupied by its first quota of boys and girls, according to an announcement from Nassau County Sanatorium, Farmingdale, N. Y.

The purpose of the preventorium is to care for children predisposed to tuberculosis, also those suffering from malnutrition and rickets. A limited number of children with heart disease will be admitted.

The preventorium building is a unit of the Nassau County Sanatorium, but is a separate structure, so that there will be no contact between children and adult patients. Two schoolrooms have been provided and a limited curriculum is to be carried on, with full-time teachers. The windows are made of a special glass that permits the passage of the violet rays of the sun. There are two sun porches with open decks and two rooms for artificial light treatment on cloudy days. On the second floor are two wards of eleven beds each, with a glass partition between each bed.

Extensive recreation facilities will be a feature of the preventorium. These include a swimming pool, which will be used for skating in winter, croquet grounds and a playground with a rectangular walk six feet wide, on which the children may enjoy roller skating, ride bicycles and have similar pleasures.

There are accommodations for the care of eighty children.

ST. MARK'S HOSPITAL GIVES SPECIAL TRAINING TO MISSIONARY

Rev. William E. Nelson, a missionary of Portuguese West Africa, a region formerly inhabited by cannibals and where no doctor is within four or five hundred miles, has been in America on leave, and while in New York recently has taken some special training in the essentials of field medicine at St. Mark's Hospital.

Dr. John F. Bresnahan, medical director of the hospital, became acquainted with Mr. Nelson while traveling in Africa three years ago, and during Mr. Nelson's visit to this country Dr. Bresnahan made arrangements for him to enter St. Mark's and take a course in the laboratory, surgical, dispensary and other departments. A knowledge of the fundamentals of first aid and emergency surgery will be of value to Mr. Nelson on his return to the missionary field shortly.

OAKLAND, CALIF., TO HAVE NEW HOSPITAL

Financing has been completed, ground purchased and plans and specifications prepared for a new seven-story hospital to be erected in Oakland, Calif., to be known as the Hillcrest Hospital, according to Charles D. Bates, president of the Hillcrest Hospital Company. Construction is to start immediately and it is expected that the hospital will be ready for occupancy by May, 1928. There will be accommodations for 140 patients and the architecture will be an adaptation of the Florentine type, with Italian detail.

The building will be fireproof and earthquakeproof, it is said. Communication between the main building and adjoining power house and laundry building will be by means of an underground tunnel. Particular attention has been paid to the dietary department, all preparatory service being centralized in one kitchen on the main floor, with separate pastry room, scullery, meat and vegetable rooms and cold storage.

The consultant in the planning of this building is Dr. R. G. Brodrick, Stanford University Hospitals, San Francisco, Calif.

TRIBUTE PLANNED TO ONE OF GEORGIA'S OUTSTANDING EDUCATORS

The alumnae of Georgia State College for Women is raising a sum of \$50,000 to be used in building a hospital on the college campus at Milledgeville, Ga., in memory of Dr. Marvin M. Parks, who for more than twenty years served the college.

FORT WORTH HOSPITAL ENDOWED

A fund given by Mrs. W. I. Cook, Albany, amounting to \$1,150,000, for the erection of a hospital at Fort Worth, Texas, to be a memorial to her husband and to her daughter, has recently been announced. The hospital is to cost \$650,000 and the balance of the money will be used as an endowment fund. Contracts for the building have been let and it is expected that the building will be completed within nine months. One of the functions of the new hospital will be to give care to girls and women who are ill and short of funds. Charity work of this kind will be a feature of the institution.

PAMPHLET FOR USE OF MENTAL HOSPITALS PUBLISHED

The Department of Statistics of the National Committee for Mental Hygiene has just published a new edition of the "Statistical Manual for the Use of Hospitals for Mental Diseases." It contains the classification of mental diseases adopted by the American Psychiatric Association and suggestions for diagnosis, for the recording of data concerning admissions, discharges and deaths, and for the compilation of annual statistics in accordance with a uniform system.

This pamphlet may be obtained for a nominal price from the National Committee for Mental Hygiene, 370 Seventh Avenue, New York.

ROCKEFELLER FOUNDATION AIDS UNIVERSITY OF OREGON MEDICAL SCHOOL

The university of Oregon Medical School announces an appropriation of \$130,000 by the General Education Board of the Rockefeller Foundation. Of this amount \$63,000 is to be expended for equipment for the Portland medical center, which includes the medical school, Doernbecher Memorial Hospital, Multnomah County Hospital and the Portland Free Dispensary.

News of the Month

WESTERN RESERVE MEDICAL CENTER TO HAVE NEW UNITS

The sum of \$6,000,000 needed to provide new units for the Western Reserve University Medical Center, Cleveland, has been more than subscribed, as the result of the recent campaign.

It is planned to erect a new home for Lakeside Hospital, for the study and treatment of patients suffering from all types of diseases; a new Rainbow Hospital for Crippled Children and a new nurses' dormitory. Samuel Mather, Cleveland, subscribed \$1,000,000 and a similar sum was donated by Edward Stephen Harkness, New York. Besides these contributions two special gifts, totaling \$1,500,000, were made for special units not included in the original plans.

FRANCE HONORS DR. BILLINGS

Dr. Frank Billings, Chicago, was recently made an officer of the Legion of Honor. This distinction was conferred on Dr. Billings in connection with his work as chairman of the committee to collect funds for a monument to be erected to Louis Pasteur in Chicago. Dr. Billings at one time served in the laboratories under Pasteur and in 1886 brought to Chicago its first bacteriological outfit for cultivating bacteria. Dr. Billings made a significant contribution to the hospital field by serving for four years as the first president of the American Conference on Hospital Service.

GENEROUS GIFT TO NORWALK HOSPITAL ANNOUNCED

A new unit, completely equipped, will be added to the Norwalk General Hospital, Norwalk, Conn., through the generosity of Edward T. Bedford, Westport, Conn., who has donated a sum of \$500,000 for this purpose. This addition to the hospital will more than double its capacity, which at present is ninety-three beds. It is estimated that the new structure will cost \$350,000, and the remainder of the money will be used for equipment.

NURSES' HOME, DISPENSARY AND LABORATORY COMPLETED AT MOUNT SINAI

On June 2 the three new units that have been added to Mount Sinai Hospital, Cleveland, were formally dedicated and thrown open for service. These comprise a nurses' home, a dispensary and a laboratory, and the buildings have been erected at a cost of \$1,350,000, raised by subscription.

The nurses' home is a six-story brick and stone building in the Georgian style of architecture. Each nurse will have a separate room in this home, and on every floor is a large room for social intercourse, and a small "fudge" kitchen. On the roof is a solarium. A long corridor connects the home with the hospital.

The laboratory is an addition to the hospital proper and is modernly equipped. On the first two floors are the admitting suite, laboratories and autopsy room. The upper floors are occupied by the interns.

The out-patient building is planned to accommodate approximately 100,000 cases a year. There are twenty-two clinics, waiting rooms, pharmacy, social service room and record room. There are a number of private rooms for examinations for diagnosis, and for cardiac patients there are private soundproof rooms.

NEW MATERNITY HOSPITAL OPENED IN ST. LOUIS

The new St. Louis Maternity Hospital, St. Louis, Mo., that has been erected adjoining Barnes Hospital and the Washington University School of Medicine, was opened for occupancy early in July. This hospital was previously independent but will now be affiliated with the university. It will continue to have an independent board of directors but the medical supervision will be in the hands of the university.

The hospital is an eight-story building and will accommodate 103 mothers and an equal number of infants. Sixty of the beds will be used for teaching purposes; forty-three will be for private patients. There are eight delivery rooms, one operating room, an isolation division of eight beds, a large solarium, research laboratories and departmental offices. One floor is reserved for colored patients, who have their own delivery rooms and separate entrance.

The maternity division of Barnes Hospital will be transferred to the new maternity hospital.

LUTHERAN HOSPITAL OF MANHATTAN TO ERECT NEW BUILDING

The Lutheran Hospital of Manhattan, New York, plans to erect a \$750,000 hospital on land to which it has just taken title in the Fort Washington section of Washington Heights. Plans for the structure have been prepared by Crow, Lewis & Wick, architects, New York. The hospital's present building is overcrowded and it is hoped in the future to enlarge and broaden the service to the middle class and poor of New York City done by this hospital, according to E. F. Eilert, president of the hospital.

LYNN HOSPITAL OPENS CANCER CLINIC

Lynn Hospital, Lynn, Mass., recently opened a cancer clinic, under the direction of the cancer committee of the Lynn Medical Fraternity, in cooperation with the Massachusetts State Department of Health. The number of patients on the first day was ten. Of these six were found to be suffering from cancer. The State Department of Health will supply a consultation service composed of members of the medical profession renowned for their skill in this field of medicine.

In conjunction with the cancer committee, a lay committee, composed of about twenty citizens of greater Lynn, will act as a committee on cancer education, in the hope of bringing more cancer cases under adequate treatment at an earlier period of the disease than has before been possible.

News of the Month

A. H. A. NEEDS ASSISTANT SECRETARY

The board of trustees of the American Hospital Association at its last meeting, held in Chicago on June 18, 1927, unanimously passed a resolution, creating the position of assistant secretary.

It has been the board's feeling for some time that the association's headquarters should be more closely brought in contact with hospitals in the field, and that the American Hospital Association should be rendering greater service to those hospitals than it has been able to render in the past.

The board of trustees, in approving this new position, is desirous of securing a man who will be able to visit hospitals upon its request, and to furnish any help the individual hospital seems to need.

The board feels that this man should be one who can speak well; is able to write easily, and who will in every respect be a high-type representative of the American Hospital Association in the field.

Dr. Joseph C. Doane, Philadelphia, is chairman of a committee that has been appointed to endeavor to locate such a man.

This committee would be glad to hear from persons who feel that they are qualified to perform this service.

CATHOLIC NURSES MEET AT MILWAUKEE

Thursday, June 23, was the International Catholic Guild of Nurses' day at the Clinical Congress of North America, which convened in Milwaukee, Wis., from June 20 to 24, inclusive.

On the evening of June 22 the guild members and their friends were entertained at a banquet and social evening by the Milwaukee group of the guild, the banquet being given at the Plankinton Hotel.

The speakers of the evening were Rev. A. C. Fox, president, Marquette University; Rev. E. F. Gareshe, S.J., Milwaukee; Meta Pennock, editor, the *Trained Nurse*, New York; Mary Roberts, editor, the *American Journal of Nursing*, New York, and other prominent leaders of the nursing profession. A short talk was also given by Lyda O'Shea, R.N., president of the guild. Philip Grau, Milwaukee Association of Commerce, Milwaukee, was the toastmaster.

On Thursday, June 23, Father Gareshe presided at the morning session. The president's address was read by Lyda O'Shea, and the message dwelt especially on the purpose and activities of the guild and its progress and problems during the year.

Two papers dealing with the correlation of theory and practice in schools of nursing were given by Sister Helen Jarell, Chicago, and Sister Mary Lidwina, Chicago, Sister Jarell discussing the theoretical side and Sister Lidwina discussing the practical side of the question. The papers were comprehensive as to subject matter and clearly illustrated the planned schedule carried out by such schools of nursing as are affiliated with universities.

These papers were followed by an interesting discussion on "Organization, Management and Procedure of Schools of Nursing," by Laura R. Logan, R. N., dean, Illinois Training School for Nurses, Chicago.

The afternoon program consisted of a round table con-

ference, conducted by Lyda O'Shea. The problems discussed covered the subject of making the nurse more efficient and her services more far-reaching, particular stress being laid on the suggestions that psychiatry, public health and tuberculosis find a more important place in the nurse's education.

An important note was struck by a paper read by Caroline Soellner, R.N., on "Special and Group Nursing." Miss Soellner advanced many excellent ideas of meeting with this problem, which is commanding the attention of the hospital world today. The paper was discussed intelligently and instructively by Mary Walsh, Mercy Hospital, Gary, Ind., who outlined in detail the plan inaugurated at her hospital. The success of the plan, she stated, depends entirely on all the factors involved, the patient, the physician, the hospital and the nurse. Under this plan of group nursing the nurse is provided with more hours of sleep, relaxation and recreation.

OPEN FORUMS TO FEATURE PROTESTANT MEETING

At the meeting of the American Protestant Hospital Association, to be held at Minneapolis, Minn., in October, much prominence will be given to open the forum method of presenting topics and arousing discussion. The subject of efficient administration will be stressed and such questions as the following will be considered: What does an administrator administer? How can satisfaction be assured while practicing wholesome economy? Is it possible for the chief executive to maintain poise while under criticism? What are the governing principles of a well balanced and resourceful administrator?

A banquet will be held on Saturday evening, October 8, and at the Sunday evening meeting the Right Rev. James Wise, bishop of the Topeka Diocese, Topeka, Kans., will give the annual address.

DR. J. L. McELROY GOES TO ST. LUKE'S, CHICAGO

Dr. Jesse L. McElroy has been appointed superintendent of St. Luke's Hospital, Chicago, to succeed Dr. C. H. Pelton, who goes to Montefiore Hospital, Pittsburgh. Dr. McElroy was until recently superintendent of the University Hospital, Iowa City, Iowa. He assumed his duties at St. Luke's Hospital July 15.

FLORIDA HOSPITAL EXECUTIVES ORGANIZE

Plans laid by a committee of hospital executives of Jacksonville, Fla., have culminated in the organization of the Florida Hospital Association, Incorporated, of which Fred M. Walker, superintendent, Duval County Hospital, Jacksonville, is the newly appointed president.

The sessions of the first meeting were devoted exclusively to business and at that time a constitution and by-laws were adopted and executive officers for the new association were elected.

The new association will affiliate with the American Hospital Association, and will act as the State of Florida section of the national association.

News of the Month

ENDICOTT, N. Y., HAS NEW MUNICIPAL HOSPITAL

"Ideal Hospital" has been officially adopted as the name of the new municipal hospital at Endicott, N. Y., formally opened June 26. The institution has a total capacity of 104 beds, forty-four of which are now available for patients, thirty-eight for adults and six for children. Eighteen of the beds will be for private patients and there will be one children's ward of six beds and four adult wards of five beds each. Sun parlors and porches are provided for convalescent patients. The hospital has a modernly equipped laboratory and x-ray department on the fourth floor.

At the top of the building are the two operating rooms, on the northwest corner, where sunlight streams in through many windows. The walls are tiled in a gray-blue shade.

The hospital was built at a cost of \$328,000, and was made possible largely through the generosity of George F. Johnson, Endicott, who contributed \$150,000 toward the cost of its construction.

MARGARET J. ROBINSON RESIGNS FROM MONTEFIORE HOSPITAL

Margaret J. Robinson has resigned from the superintendency of Montefiore Hospital, Pittsburgh, and the position is to be filled by Dr. C. H. Pelton, superintendent, St. Luke's Hospital, Chicago, formerly of Elyria Memorial Hospital, Elyria, Ohio.

N. Y. SUPERINTENDENTS ENTERTAINED AT GRASSLANDS HOSPITAL

The Westchester County Hospital Association entertained the superintendents of the hospitals of the five boroughs of Greater New York at a field day picnic and dancing party on June 23. The association entertained its guests on the grounds and in the buildings of Grasslands Hospital, which is the Westchester County General Hospital. Many of the guests found pleasure in using the swimming pool in Westchester Hall, the hospital's new nurses' residence; others took walks about the 600-acre hospital farm or played outdoor games. The attendance from Westchester and from New York City was about seventy-five. A meeting of this sort is an annual event, and those attending consider it valuable in its recreational features, as well as in the opportunity it affords for discussing problems of mutual interest.

HARTFORD HOSPITAL TO RECEIVE NEW LIBRARY

A memorial library is to be presented to the Hartford Hospital, Hartford, Conn., by Col. Louis R. Cheney and his daughter Mrs. John T. Roberts, in memory of Mrs. Mary Cheney, the first president of the women's auxiliary of the hospital. Colonel Cheney has been president of the hospital for the past nine years and a member of its executive committee for twenty-seven years.

The library building will cost approximately \$75,000 and will be a three-story structure. The two upper floors will provide quarters for about eighteen members of the staff and the library will be housed on the first floor, extending the entire length of the building. It is estimated that 6,000 books can be placed in the library proper, while in the basement there will be additional stacks that will hold more than 10,000 volumes.

MICHIGAN HOSPITAL ASSOCIATION HOLDS MEETING IN JUNE

The Michigan Hospital Association held a get-together meeting June 24 and 25 at the Kalamazoo State Hospital, Kalamazoo. Papers were presented dealing with the correlation of psychiatric and general hospital problems; hospitalization of employees; occupational therapy; and the nursing school in relation to the hospital. Among those taking part in the program were Dr. Herman Ostrander, Kalamazoo State Hospital, Kalamazoo; Lola Schmidt, Battle Creek Sanitarium, Battle Creek, and Dr. Stewart Hamilton, Harper Hospital, Detroit. No business was transacted at this meeting.

COUNTY HOSPITAL PLANNED FOR PIKE COUNTY, MO.

Plans are being drawn for a fifty-bed county hospital to be erected at Louisiana, Pike County, Mo., the building to cost \$140,000. When the building is completed and equipped the hospital will be turned over to Pike County for maintenance.

The erection of this hospital has been made possible through the merging of two funds, one fund established by the late Susanneli Barr and the other left by the late Otis Smith, New York, both funds being established for the purpose of erecting a hospital in Louisiana. The Barr fund amounts to \$25,000 and the Smith fund to \$100,000.

MARY IMMACULATE HOSPITAL TO HAVE NEW HOME

Over 16,000 families have contributed to the building fund of the new Mary Immaculate Hospital now under construction at Jamaica, Long Island, N. Y. The new building will cost approximately \$1,750,000 and can accommodate 7,800 cases annually. It will serve a territory covering about fifty square miles, with a population of more than 450,000. The hospital will be of the most modern type and will be well equipped.

CHILDREN IN MEXICO TO BE GIVEN FEVER TESTS

The Federal Government of Mexico has ordered that all children must be given the Schick test for diphtheria and the Dick test for scarlet fever before they can enter public school or kindergarten. If there is a positive reaction they are given preventive treatment. Both the treatment and the tests are free.

YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. THE MODERN HOSPITAL will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

How Much Vacation and Sick Leave Should Be Granted the Nurse?

For some time, the proper length of vacations for hospital personnel has been the subject of considerable study by hospital organizations and by individual hospitals. It is impossible to set down any hard and fast rule in discussing the vacation that is due any group of the hospital's personnel.

In many hospitals, it is the custom to grant a fourteen days' vacation to the pupil nurse, and thirty days' leave, with pay, to the graduate nurse in charge of the major departments.

It is a difficult matter to fix the length of vacation of any group so that it will be in proportion to its responsibility and efficiency. It would seem that if the graduate nurse in charge of a department receives thirty days' vacation, the general duty nurse who has not the same administrative responsibility should receive a shorter vacation than her superior. On the other hand, most hospital superintendents have come to believe that an adequate vacation is a paying investment, from the standpoint of maintaining a healthy hospital efficiency and morale.

Although it is not usually done, it would appear to be wise to grant suitable vacations, even though extra help were necessary during the summer period. The problem often arises as to whether a nurse who begins her work with a particular hospital, let us say, in January, should receive her full vacation in July. The rule sometimes exists that no vacation is due until a six months' period of service has been terminated and but one-half of the total vacation is to be then allotted. On the other hand, if a competent and conscientious nurse terminates, for example, a service in another hospital in January, and begins her new duties without an intervening rest, it seems unjust to force her to wait until the end of the year to take a vacation.

If the superintendent of nurses feels that a particular nurse is physically and mentally in need of recreation, and that she is intending to remain with the hospital at least throughout the entire year, it would seem good judgment to allow this nurse to take her full vacation at the conclusion of six months' service, with the understanding that should she not complete a year's service and thus have earned a full vacation, the difference in money representing this unearned vacation, would be deducted from her last month's salary.

After all, the question of vacations must be handled as many other matters in the hospital are, by consideration

of the needs of the individual being planned for.

In so far as the sick leave is concerned, it is the custom in some institutions to grant to the members of its nursing staff, thirty days' leave, with pay, in the course of every twelve months.

On the other hand, a nurse who contracts a contagious disease while employed in a hospital of this type, certainly deserves to be carried on the institution's pay roll until she is fully recovered. A nurse who contracts typhoid fever while caring for a patient with this disease, should be maintained on the pay roll until she is able to return to her duty. A nurse who becomes ill with a disease in no way connected with her work, should not expect a longer period, under pay, than thirty days, which is a liberal allowance.

In the same way, a nurse who is in an automobile accident, or falls and receives a surgical injury while off duty, should not be paid for as long a period of time as the nurse who receives her injury while in the pursuit of her duty, whether within or without the hospital.

The length of time that the nurse has spent in the service of the institution, should also be taken into consideration. The graduate nurse who becomes ill with a condition not in any way connected with her work, during the first few months of her employment in a particular hospital, should be allowed only a fractional part of the sick time usually granted, whereas the nurse who has been longer with the institution should receive a more extended leave with pay.

Whether or not the hospital supplies free treatment to the members of its personnel when ill, also, in a way, alters the problem. It has been found that the hospital that deals generously with its sick and injured employees, usually receives more whole-hearted loyalty from these persons than is the case where a less broad-minded policy is adopted.

What Is the Acute Hospital's Obligation to the Chronic Patient?

No more troublesome problem confronts the acute hospital than the discharge of its obligation to the chronically sick. On the other hand, the chronic patient is likely to make it difficult for the acute hospital to render to its community the amount of service per bed that it should. The definition of chronicity is one that has many local variations. A case of valvular heart disease certainly becomes acute when decompensation sets in and the patient is unable to provide for his family. After a variable number of days' treatment, even though heart balance is partially restored, the patient is usually unable to return to his work.

Has the acute hospital a further obligation to this patient? In many localities no provision has been made for the care of this type of illness beyond a certain limited study in the community hospital. Should the hospital de-

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Many physicians have met with marked and sometimes seeming miraculous success in using the light from these carbons as a remedial agent. The place of carbon arc light therapy in preventive medicine likewise is becoming more and more firmly established daily.

Full descriptions of the physical characteristics of these carbons, including spectrograms, are given in the new booklet, "National Therapeutic Arc Carbons," just issued. This enables the physician to select the proper types of carbon to give the quality of light he desires for the treatment of his cases. The booklet is sent free on request to physicians and hospitals. National Therapeutic Carbons are sold by lamp manufacturers and physicians' supply houses.



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For complete index of advertisements refer to the Classified Directory

mand this patient's removal, even though it might work a hardship and a harm to the individual man or woman? What is to be done if the patient has no home to which to go? If there is a home and the surroundings are reasonably comfortable such patients may often be adequately cared for there. However the hospital often must furnish transportation when the transfer from its wards to the home takes place.

Visiting nurse organizations, such as exist in many of our cities are able to furnish, at a minimum cost, the required amount of nursing in the home in certain types of illness. In any event, the social service department of the hospital in which the patient has been treated should keep in touch with the home situation.

In localities that are fortunate enough to possess bed facilities for the chronically ill this problem is much simplified. Even although a sound basic principle in conducting a hospital is to return the greatest good to the greatest number, fairness to the individual requires that no ironclad general rule be adopted that will demand the removal of the chronic patient to unsuitable surroundings without some constructive plan having been made for his welfare.

To insist that each bed must care for one and one-half or two patients monthly is an excellent general rule, but this edict must often be broken in favor of the patient suffering with a subacute or chronic ailment. Moreover, one of the greatest needs that exists, in rural districts particularly, is provision for the care of the chronically ill, many of whom have never been hospitalized. To force a man or woman who has formerly enjoyed better circumstances and sounder health, to seek entrance to an almshouse that has no hospital facilities, is the acme of injustice to the individual.

How Can Student Nurses Be Prevented From Self-Dosage?

Many a directress of nurses has been driven to distraction in her attempt to prevent student nurses from prescribing for themselves. In this instance, particularly, is a little knowledge a dangerous thing. The student nurse learns in her classes that a certain drug is useful in a certain condition, and, showing symptoms of such a condition, she proceeds to prescribe for her troubles.

Many experienced hospital administrators have observed distressing results from this practice on the part of young nurses. Indeed, when one remembers the dangers of such drugs as the opiates, cocaine, and even some of the coal-tar products, from the standpoint of habit formation, it becomes evident that a strict rule must exist forbidding the student nurse to take any drug of any sort during her course of instruction. This is an easier rule to enact than to enforce, and implies that the hospital must supply constant and efficient medical supervision for the members of its school for nurses. If nurses are forbidden to prescribe for themselves, then there must be someone who is constantly available to prescribe for them. Most schools of size possess a physician who holds clinics twice daily for the examination and treatment of members of its personnel seeking medical aid. It is a good plan to secure, if possible, a woman doctor for this purpose. It may be necessary for the hospital to pay her a moderate salary for this service, but it is worth while, and is money well spent.

The practice of preventive medicine in the school for nurses has reached a point where the young probationer should not be allowed to mingle with patients until she has been immunized against typhoid fever, diphtheria and

possibly scarlet fever, and this physician can promptly carry out the initial physical examinations of newcomers in the school, as well as the immunologic steps to which reference has been made.

This rule is more likely to be carefully observed if the instructor of nurses explains in detail the dangers incident to the promiscuous ingestion of drugs. It is a regrettable fact that from the medical and nursing professions is drawn a too large percentage of those persons who find themselves enslaved as a result of the non-medical use of a narcotic, and in some cases, this habit has been traced to lack of proper instruction during hospital days. A sympathetic attitude on the part of hospital executives, in regard to forcing nurses to continue on duty when ill and particularly if incapacitated during the menstrual period, would tend to prevent self-dosage. In cases where nurses do not regard this rule seriously, an occasional suspension, or even expulsion from the school, will serve as a curb in so far as the other students are concerned.

The chief point to remember is that the hospital must supply adequate medical supervision for nurses who are ill, and that it must endeavor to provide careful and thorough instruction in regard to the dangers that lurk in self-prescribing.

How Can Incompetent and Unnecessary Surgery Be Prevented?

In closed hospitals this question can be easily answered by stating that only such physicians should be allowed to practice in the institution as have demonstrated a special ability in the branch of medicine in which they profess to specialize. In the open hospital the problem is not always an easy one to solve.

In some localities every physician who desires to treat patients in the hospital must fill out a detailed application blank, setting forth his training and fitness to treat the patient. For example, a physician applying for the privilege of using the institution's operating room is required to demonstrate his training as a surgeon.

In some hospitals the surgical committee of the staff requires that the applicant perform his first operation in its presence. In others, some physician, acting as a committee of one, is delegated to investigate the fitness of the applicant and to be present when he operates.

A hospital has a distinct responsibility in this matter, and since its good name is decidedly harmed by unethical procedures carried on within its doors, too strict a supervision of physicians applying for house privileges cannot be adopted. Even in closed hospitals visiting physicians are sometimes prone to place too much responsibility in the hands of their assistants, particularly when it comes to treating ward patients. The board of trustees should scrutinize the names submitted to it for appointment as assistant physicians and surgeons, almost as carefully as those for appointment as chiefs. It is thought by some that annual appointment of the members of the hospital staff stimulates interest and care in the treatment of patients.

The monthly conference as outlined by the American College of Surgeons is one of the best protective measures in so far as safeguarding the interests of the individual patient is concerned. An unusual number of infections or of deaths in conditions where recovery usually takes place, invites a careful scrutiny by the staff and the superintendent as to the reason therefor. Incompetency of physicians, and of surgeons particularly, is likely to be demonstrated by these carefully conducted monthly surveys of the hospital's work.

*From an Article in a
Leading Medical Journal*

"Recently we have given 6 newborn babies whole lactic acid milk with Karo one ounce to the quart as a complementary feeding when we found the maternal milk supply inadequate after the fourth day, and when we have been unable, by emptying the breast after each nursing by manual expression, to increase the supply sufficiently. They apparently digest this milk with its 3.5 to 4 per cent fat and its 3.5 per cent protein, and do well on it without signs of gastric or intestinal indigestion."

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Should the Acute Hospital Have an Occupational Therapy Department?

The superintendent who asked this question of THE MODERN HOSPITAL desired information on the subject because of his belief that in an acute hospital with a turnover of two patients per month per bed, the expenditure of money for the salary of a worker and for the supplies needed was not justified.

It is a fact that in many acute hospitals there is no occupational therapy department, and that this activity is more often found in chronic, state and municipal institutions, particularly in hospitals for mental diseases.

On the other hand, good occupational therapy offers much that is of benefit to any type of patient. It is particularly useful to the patient who is much concerned about his own welfare and whose worry delays convalescence. Here it possesses a distinct psychotherapeutic value. From the standpoint of the physical good of the patient, occupational therapy has much to recommend it. In the orthopedic and general surgical wards, the occupational therapist can perform a useful function in encouraging the use of stiffened joints, and in speeding the return of function in cases where nerves have been injured or muscles atrophied as a result of disease.

There are also, even in an acute hospital, patients whose stay is prolonged much over the average fifteen-day limit. There are patients, the nature of whose injuries may prevent their re-entrance into the business or trade formerly followed. It is not an infrequent occurrence for the occupational therapist to be able to divert the interest and efforts of such a patient along lines that will make him self-supporting upon his discharge from the hospital.

On the other hand, it cannot be too strongly stressed that occupational therapy should be therapeutic and not commercial in its tendency, and that a basket that appears crude to the casual observer may assume the proportions of a masterpiece when he sees the patient.

The occupational therapy department may be of service to the hospital by the preparation of garments used in its various wards, and in the manufacture of gauze products needed in the surgical department.

But perhaps the greatest service that the occupational therapy department may render to the hospital is the prevention of prolonged hospitalization on the part of patients whose mental inertia is out of proportion to their physical strength. That patient is indeed unfortunate who has lost the desire to get well speedily.

Not only is the occupational therapy department of service to the acute hospital in so far as its surgical patients are concerned, but the cardiac cripple, the chronic nephritic and many other types of medical patients can be usefully and pleasantly employed even while they are still confined to bed. In a general acute hospital, therefore, the occupational therapist has much to offer in speeding the return to health of its patients, and in the establishment of that intangible thing which is called "hospital morale."

Who Should Treat Fractures in the Hospital?

It has been said, and with not a little truth, that many fracture patients in our hospitals do not receive the attention they require and deserve. Fractures of the lower portions of the tibia and fibula are oftentimes seen in the hospital dispensary or admission ward. After a diagnosis is made, the patient may be put to bed in the accident ward but not actually admitted to the surgical ward proper. A cast is then applied and the patient is observed

for from twenty-four to seventy-two hours, and then discharged. When he goes to his home and swelling subsides, the fragments are likely to become displaced because the cast is no longer capable of giving the proper support. He is told to return to the dispensary for supervision. He may or may not do this, and as a result he may have a malunion.

There are few other injuries that so completely incapacitate a worker as does a fracture of a long bone or even some short bones. The average intern in the hospital's out-patient department is not skilled to a sufficient degree to allow him to assume all the responsibility of the treatment of fractures. The assistant chief or the chief surgeon himself should be responsible for these cases.

In some institutions a definite fracture service has been organized, a well trained physician being assigned to this work for a full year's service. This seems to be a good scheme. The fact that many hospitals object to housing a fracture patient until the cast can be removed, brings about the temptation to discharge these patients before the adequacy of treatment can be certainly judged. If this is done a social service follow-up should be inaugurated so that these cases do not become lost until the result of treatment can be learned, and until massage, baking and exercise can bring about a complete restoration to function.

If no fracture service exists, frequent changing of surgical chiefs is likely to work a hardship to the patient and to delay x-ray and other studies, because the patient was previously treated on the service of another surgeon.

It cannot be said with too much emphasis that while young physicians must secure experience in the treatment of fractures, this experience cannot be gained at the expense of the patient, and that treatment of fractures must be performed under the watchful eye of a skilled and experienced surgeon. If patients must be discharged with casts in place, they should be inspected or x-rayed on several occasions before union is complete, or the deformity in unfortunate cases permanent.

Should Patients Be Allowed to Choose Physicians Who Are not on the Hospital Staff?

This question was asked by the superintendent of a hospital that has a regular, well organized hospital staff. The patients to whom reference has been made were non-paying patients, and in some cases came to the hospital from a neighboring charitable home. These patients insisted upon being treated in the hospital by a physician of their own choosing and not by a member of the hospital staff.

If a hospital possesses a staff of well qualified physicians, as it should, the superintendent should not permit patients to demand the service of other physicians than those provided by the hospital.

This problem sometimes is presented from a slightly different angle. Nurses and physicians who become ill request the presence of physicians not on the hospital staff. Hospital superintendents are then somewhat in a dilemma as to whether to yield to the requests of faithful hospital workers or to enforce the existing rules, in letter as well as in spirit. Usually when such a problem arises the superintendent is inclined to yield and allow outside physicians to visit the hospital, provided they are ethical and their scientific reputation is good.

It would seem, however, that in the above case the superintendent of the hospital was justified in stating that physicians not on the staff could not be called for the treatment of charitable ward patients.

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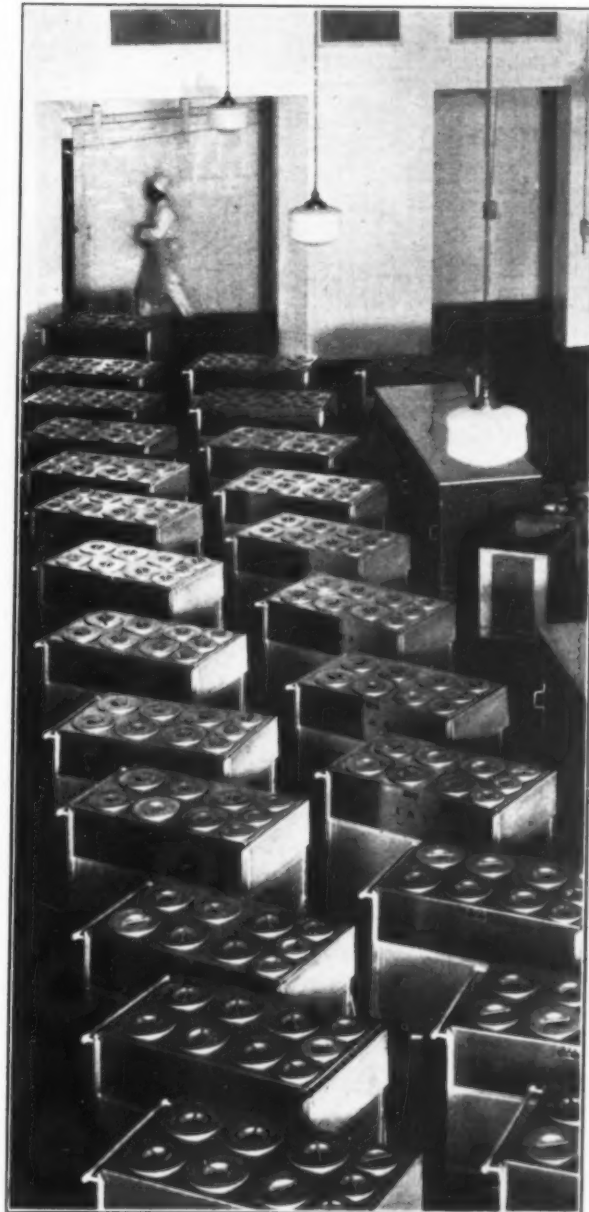
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WHERE THE CONVALESCENT MAY RECUPERATE

NO BARRIER of race, creed or sex surrounds the Home for Convalescents maintained in connection with the Presbyterian Home for the Aged, Evanston, Ill.—Jew or Gentile, Protestant or Catholic, all are equally welcome. If you are over sixteen years and convalescing from the effects of an operation or a serious illness you may go there and “stay and rest awhile.”

This convalescent home went into operation about two years ago and has accommodations for twenty patients, in one wing of the large and modernly equipped Home for the Aged maintained by the Chicago Presbytery.

The building lies west of Evanston in a quiet spot, surrounded by shady trees. The grounds extend over forty acres and are attractively laid out. Flowers abound there in summer time and there are sheltered walks where patients can take exercise in the open air.

The bedrooms are pleasant, airy and well lighted and there are two sun-suffused solariums where patients lounge in easy chairs and read or work or rest, and enjoy the cheerful companionship of others. All the rooms are on the second floor and the building contains an elevator for the use of those who are unable to use stairs.

Rates Are Low

The rates charged at this home are extremely moderate—\$10 a week for a single room and \$7 a week per person for a double room, including three meals a day and a light lunch of crackers and milk at 8:30 p.m. This of course does not cover the cost of maintaining the home, which is financed out of the general funds of the Home for the Aged. Patients are expected to give their own rooms necessary daily care. The period of stay allowed is from one week to two months, as may be necessary or advisable.

No medical treatment is given except in emergencies and no special diet is provided. Everybody lives like

everybody else. Cases of organic heart disease are not received and applicants for admission must be certified by a physician to be free from contagious disease of any kind. A nurse is in charge and is ever watchful for symptoms that suggest the need for medical care. If in her judgment medical advice is desirable a physician is called, and in this connection Dr. William S. White, Evanston, has volunteered his services and is at all times unsparing in his efforts to give assistance.

Diets Are Carefully Planned

The Home for Convalescents is complete in itself and is entirely separate from the Home for the Aged. All quarters, including the dining room, are shut off from the rest of the building. Diet in convalescence is of prime importance and at this home much intelligent thought is given to the planning of meals that are nourishing and appetizing. Fresh vegetables and fruit in season are served in abundance, these being grown in the Home gardens. Unlimited supplies of fresh eggs are available.

In these days when so much is heard on every hand of the lack of facilities for convalescent care, it is evident that the opportunities offered at such a home as is here described are of definite value, especially a home situated within forty-five minutes ride of Chicago, with its teeming millions of persons, its atmosphere of breathless hurry and the “Step lively!” that seems to echo for ever in the air of that somewhat hectic city.

It is well known that many persons when they are discharged from a hospital are in no fit condition to return to the “rooming” house or microscopic kitchenette apartment which is often their home. For them a few weeks in the pure country air, with nourishing food, rest and freedom from responsibility may prove a valuable opportunity to recompose the serenity of a mind that is shat-

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provided a recommendation from a physician or from a social worker familiar with the case can be produced when application is made.

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The dining room of the convalescent home.

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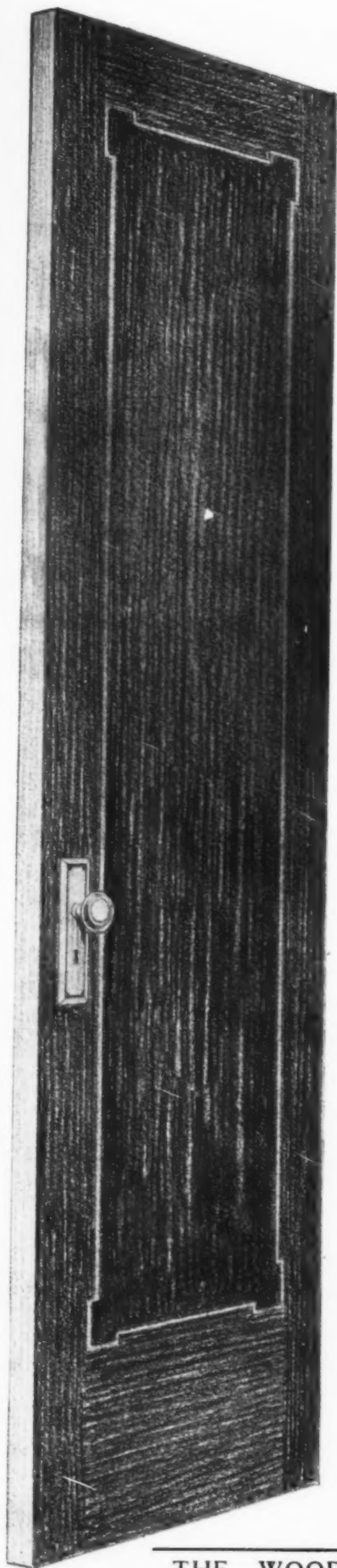
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WHAT EXECUTIVES SHOULD KNOW ABOUT THE PERPETUAL INVENTORY SYSTEM

By J. N. Hatfield, Purchasing Agent, Pennsylvania Hospital,
Philadelphia

THOSE who direct hospitals and similar institutions come to realize the advantage of efficient purchasing of equipment and stock supplies. The proper functioning of each department in a hospital depends upon suitable equipment and the availability of supplies. Because of the innumerable items used in everyday hospital routine it is necessary to store supplies. The purchase, storage, disbursement and record keeping of supplies constitute a department through which serious loss may be caused or, on the other hand, great economy effected. Purchasing will be discussed here only in its direct relation to the perpetual inventory system.

Larger hospitals find it advantageous to vest the duties of purchasing and stock control in the hands of a purchasing agent who gives his entire time to that and related work. In smaller institutions the superintendent as a rule does the purchasing, in conjunction with his other duties. In either instance it seems important that much thought be given to purchasing and that a well defined, workable and inexpensive method be used in operating a perpetual inventory.

Let us consider the subject from the standpoint of a hospital large enough to warrant employing a purchasing agent.

Requisitions Come from Two Sources

Requests for supplies and equipment are generally sent to the purchasing agent from one of two sources—the storekeeper or the head of the department making the requisition. It is the duty of the purchasing agent to investigate the need for the items requested, and when requisitions are made for articles not carried in stock, to consult the head of the department making the request as to the advisability of a substitute. If any item usually carried in stock is to be changed for something similar, it is only fair to consult the department head, since an objection may be presented that will make the contemplated change inadvisable.

At the request of the purchasing agent several business houses submit bids on the items to be purchased. For the purpose of uniformity and follow-up a "Request for Prices" form is used and upon its return or upon the expiration date, the order is placed with the concern that in the judgment of the purchasing agent offers the best proposition. The purchase order should be in triplicate. The original is forwarded to the vendor, the duplicate retained by the purchasing agent's office and the triplicate copy is sent to the storekeeper. This last copy should not show the quantity ordered, so that the storekeeper may be obliged to count and inspect every item. All copies of the order should contain full specifications, shipping instructions and any agreements whether written or verbal.

The storekeeper receives the shipment and on an "Acknowledgment" form should record the following information: Date of receipt, name of vendor, order number and the quantity and description of each item. He notes any breakage and gives any information that will aid in checking the acknowledgment with the invoice.

Every day the acknowledgments are sent to the pur-

chasing agent's office where they are filed and, upon receipt of the invoice, used as a check against the latter. If the invoice checks with the acknowledgement and conforms to the terms and agreements as written on the order, the acknowledgment is stapled to the invoice and a voucher jacket attached, showing to which accounts in the bookkeeping system the items are to be distributed and subsequently passed for payment. Immediately following the checking of the invoice and prior to its going to the bookkeeper, it is taken by the stock record clerk, in order that the items appearing thereon may be entered in the perpetual inventory record.

How Perpetual Inventory Functions

It has been shown through what stages a requested item passes, namely, the request for purchase by the storekeeper, the bids, the placing of orders, the receiving of goods, the acknowledgment to the purchasing agent's office, the checking of invoices, the designation of charges in the bookkeeping system and, finally, registration in the perpetual inventory stores record. There remains to be discussed, the functioning of the perpetual inventory, the method of keeping stores and the method of their disbursement.

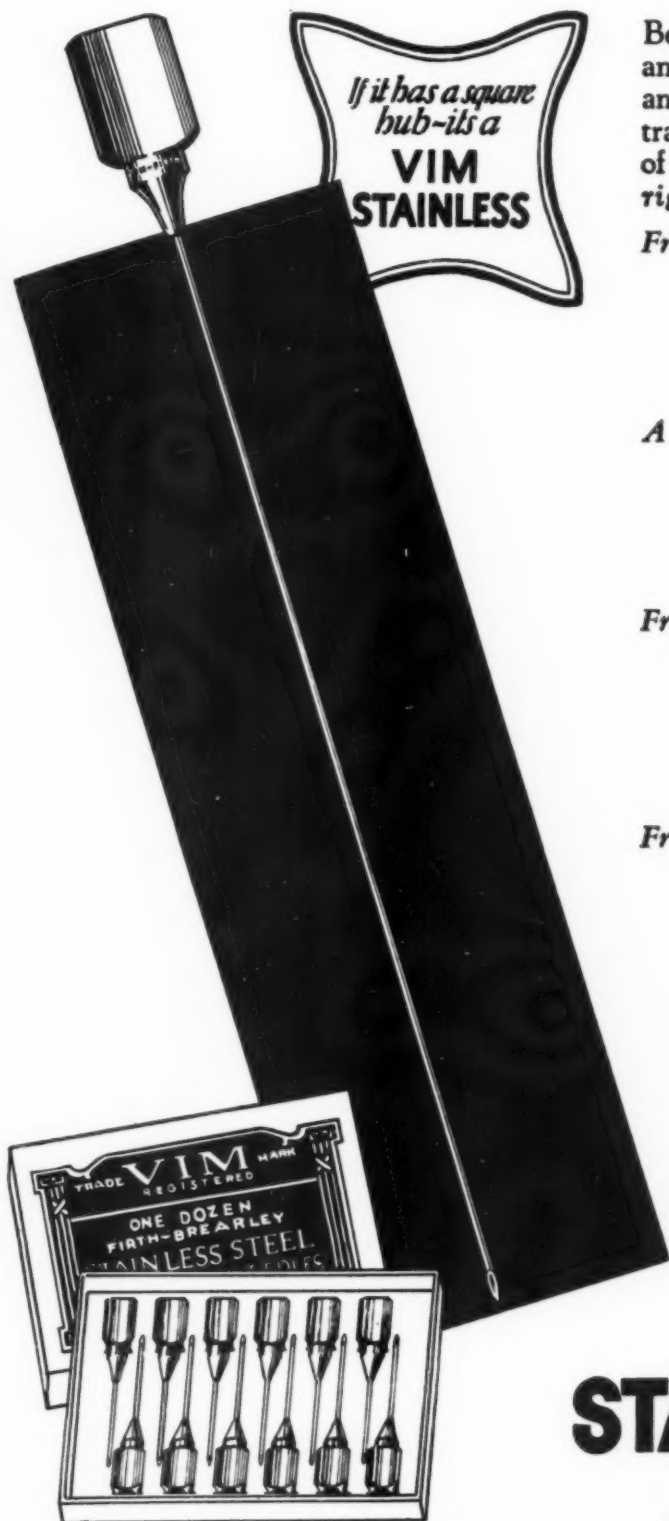
The keeping of stores is a local problem and much depends upon the construction of the buildings and their arrangement.

The stores record has two major functions: First, to inform the hospital administrator of the amount of money tied up in stores and supply an analysis of departmental and per capita costs, the latter generally applying to foodstuffs, and, second and more important, to give the purchasing agent a history of all items from the day they are received until they are issued. It supplies him with a cost analysis and notifies him regarding market conditions. It shows at any hour the stock on hand and to which departments supplies were delivered. In fact, it gives him a comprehensive picture of the stock in the storerooms at any time.

Before the stores record can be set up it is obvious that a physical inventory must be made and, in order to check the record the inventory should be taken at least once each year, with adjustments indicated. From the inventory cards the items are reposted and a recapitulation drawn off.

No stores should be taken from the storeroom except upon presentation of a "Requisition on Stores," which should bear the name of the department, list the items requested, be signed by the person making the request and be approved by the department head. The requisition is then honored by the storekeeper who makes notations where necessary to aid the stock record clerk in posting. After the requisition is filled it is signed by the storekeeper or his assistant, accompanies the supplies to the department whence it originated, is signed by the individual receiving the items and is returned to the storekeeper, from whom it is taken by the stock record clerk. The requisition is stamped with a number in a space provided for that purpose, that number being used to identify the requisition, if necessary, in the future.

Why Are Vim Stainless Steel Needles Better Than Ordinary Needles?



Because ordinary needles mean clogged bores and rusty points—endless trouble and annoyance. VIM Stainless Steel Needles on the contrary will not clog, corrode, nor rust, regardless of climatic conditions. They remain sharp, open, right. And they cost far less to use.

From an M.D. in Illinois:

"About one year ago thru some salesman I purchased one dozen of VIM Stainless Steel Needles. They are the best needles I have ever found. Will you kindly send me two dozen 25 gauge $\frac{5}{8}$ " immediately?"

A Hospital Writes:

"Your new Stainless Steel Needles are an immense success. They not only do not clog but also I think that our experience proves that they stay sharp much longer than the ordinary steel needles. We congratulate you upon this advance."

From a Surgical Instrument Dealer:

"We were one of the first dealers to begin selling VIM Stainless Steel Needles and we are pleased to advise you that now for the first time it has become a pleasure to both buy and sell Hypodermic Needles. Your product is giving splendid satisfaction."

From a City in Iowa:

"We have just completed immunization of about 1400 school children by the administration of antitoxin. We used your VIM Stainless Steel Needles along with other Hypodermic Needles and it was surprising to see how much longer the Stainless Steel Needles lasted than the ordinary ones."

For full information, prices, and name of nearest dealer, write:

MACGREGOR INSTRUMENT COMPANY

Needham BOSTON Mass.

VIM STAINLESS STEEL NEEDLES

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The stock record may be of the card or the ledger sheet type. The latter is considered here because it is compact and cheap. Where cards are used filing cabinets must be provided, and in case of large and varied stock the equipment assumes costly proportions. The cards, if large enough to contain all the information desired, are much more expensive than ledger sheets. The latter sheets are kept in loose-leaf binders.

From two to five ledgers are required, depending upon the number of items stored and upon the scope of the system. To insure ease of posting and identification it is desirable to list drugs, linens, groceries, mechanical, medical and surgical supplies in separate books. The items should be listed alphabetically and wherever possible should be grouped. For example, groceries can be grouped into cereals, fruit, spices and vegetables.

The sheets making up the ledger should be filled out according to the name of the commodity and arranged alphabetically. Each item should be thoroughly described, size and quality noted, and the unit of disbursement, together with the "Maximum Stock" and the "Normal Quantity to Order," shown. At the outset the inventory figures should be indicated in red; then follow the disbursements and receipts as they occur.

The disbursements are posted from "Requisitions on Stores," using the requisition number for identification. The date, the quantity issued, the balance, the unit price and the department distribution follow. When new stock is added, the name of the vendor, date, order number, quantity and unit are shown under the heading "Receipts." Then the quantity is added to the "Balance" column and the new price determined.

How to Figure Unit Price

The following example will show how to figure the new unit price: On the tenth of March there are 600 pounds of sugar in stock, which cost at the rate of \$0.058 per pound. On the same day is received 3,000 pounds, purchased at the rate of \$0.066 per pound. The stock is then 3,600 pounds, representing a total cost of $\$0.058 \times 600$, and $\$0.066 \times 3,000$, or \$232.80, which amount, divided by 3,600 gives the new unit price of \$0.065. This price will be used in pricing the requisition sheets until a new stock is added, which may or may not change the unit price, depending of course upon the purchase price. In order that the book value of stores may be kept near that of the actual stores value, it is important that the unit price be figured as shown above.

After the postings are made, the items on the requisitions are priced. In order to facilitate posting and for the purpose of cost analysis, the requisitions should be made out in such a way that the requests are grouped. For example, if a department is in need of linens, medical and surgical supplies and groceries, three requisitions should be used. This is best regulated by designating different days for issuing each group of items.

The total of the requisitions for any set period, which ordinarily is a month, indicates the value of the stock disbursed, and if a record has been kept of the value of the stores added, it is an easy matter to compute the value of stock on hand. For example, the inventory taken January first amounted to \$32,190.50, additions to stores during January amounted to \$8,760.50, and the disbursements were in the amount of \$9,360, leaving an inventory balance beginning February first of \$31,591.

In order to make the proper departmental charges in the bookkeeping system, it is desirable to open a "Stores" account in the "Voucher Register." The original inventory amount constitutes the first "Stores" entry and at

the end of each month, after the additions to stores are recorded and the amount of the disbursements entered, the balance is carried over to the following month. This method obviates the danger of certain items being charged to a department other than that in which they were used.

LATE DIAGNOSIS SPELLS TRAGEDY

Writing on the care of the sick in the *Canadian Nurse*, Dr. David A. Stewart, medical superintendent, Manitoba Sanatorium, Ninette, Manitoba, emphasizes the need for bringing home to the man in the street the importance of preventive rather than curative medical care.

The basis of the care of the sick is diagnosis, says Dr. Stewart, and our medical system does not allow of the maximum uses of the means of diagnosis. The commonest tragedy of practice is the tragedy of diagnosis—the man who worked until yesterday and today is found to have a hopelessly advanced disease.

Late diagnosis in pulmonary tuberculosis is the almost invariable rule, and early diagnosis the rare exception, the reason being that nothing less than advanced tuberculosis makes a man feel sick enough to call a physician. The only way to get the earlier cases under treatment is to go out and hunt for them among the apparently healthy.

The tragedies of late diagnosis need not surprise us when it is considered that the first diagnostician under our system is the patient himself. His symptoms must often be pronounced and disease must actually interfere with work before he will cross what for him is a difficult Rubicon, decide that he is a sick man and see a physician. The medical machine cannot begin to function until he has so decided.

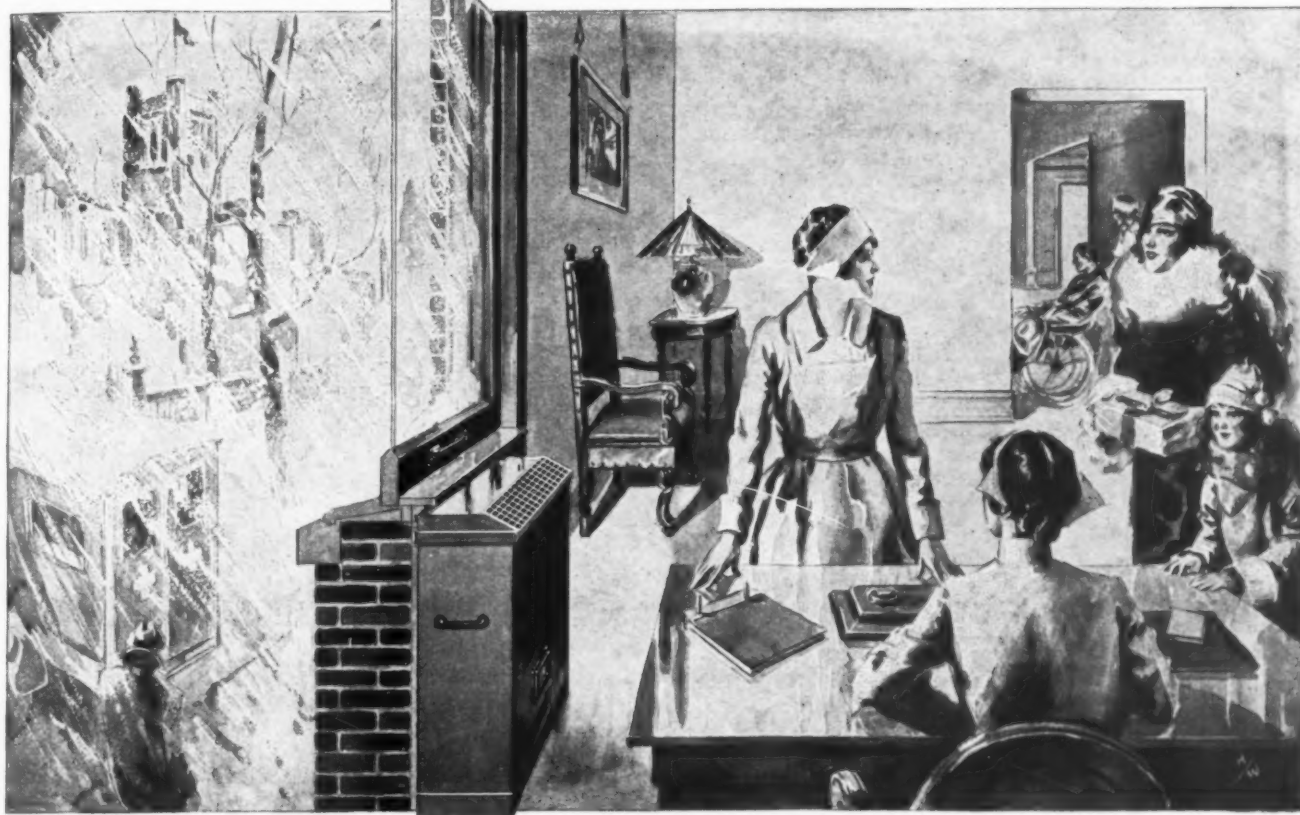
Thus physicians have advanced disease to fight, and spend days and nights finding measures to meet emergencies. Students have gross disease to study, and form their modes of thought and methods of diagnosis around it. People in general see the extremities of illness and the outcome of it, and naturally fatalism and the policy of the ostrich still prevail. And so the full round of the vicious circle is complete.

This circle will not be broken by a few new methods but only by a fundamental change in our ideas. People must realize that disease should be dealt with by prevention when possible rather than by cure; that health is easier to maintain than to restore and that medical science can help even more in keeping well than in getting well. General community health has improved wonderfully in the past few generations on the preventive plan, but the individual still clings to the curative, and our system recognizes that as the standard method. Health officers are not dismissed between epidemics but doctors are between illnesses.

HOW "BEDLAM" WAS NAMED

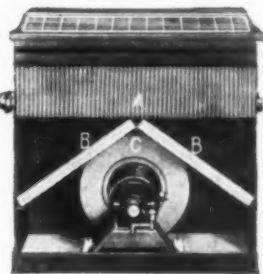
The original hospital of St. Mary of Bethlehem in London was founded as a religious priory in 1247 by Simon Fitzmary, a sheriff of London. Gradually it changed into an asylum for lunatics and shortly after 1402 it came under the protection of the City of London. When the monasteries were dissolved, the Crown gave the city a grant of the hospital and its revenues. In 1547 it was incorporated as a royal foundation for the reception of the insane. It is now known as Bethlem Royal Hospital, but with the British fondness for contracting words, this became Bedlam as early as 1863.

UNIVENT and Glass — *make the difference*



To try to ventilate a hospital through open windows has proven futile. On still days, little air comes in. On other days, blustering winds bring in smoke, soot, snow, and the distracting noise of the city. As the lesser of two evils, windows are kept closed, and patients breathe a stagnant, medicine-tainted atmosphere.

The Univent solves the problem. Windows are closed, yet stimulating outdoor air is brought INDOORS, cleaned, heated when necessary, and diffused to every nook and corner, with invigorating air motion but without draft. Clean, odorless air that lends cheerful freshness and sanitation to wards, corridors,



Open view of UNIVENT illustrating

- A—Copper radiator without a single joint, absolutely leak-proof.
- B—Air filter easily removable for cleaning.
- C—Cone type fan specially insulated for quiet operation.

UNIVENT

(TRADE MARK)

VENTILATION

Manufactured only by THE HERMAN NELSON CORPORATION, Moline, Ill.

Builders of Successful Heating and Ventilating Equipment for 20 Years

— Sales and Service —

BELFAST, ME.	SYRACUSE	PITTSBURGH	DETROIT	INDIANAPOLIS	MINNEAPOLIS	SAN FRANCISCO	SPOKANE
BOSTON	BUFFALO	ERIE	CLEVELAND	CHICAGO	ST. LOUIS	EMPORIA	PORTLAND
NEW HAVEN	PHILADELPHIA	CHARLOTTE, N. C.	COLUMBUS	DES MOINES	BIRMINGHAM	KANSAS CITY	SEATTLE
NEW YORK CITY	WASHINGTON, D. C.	GRAND RAPIDS	CINCINNATI	MILWAUKEE	ATLANTA	DENVER	VANCOUVER
UTICA	SCRANTON	SAGINAW	TOLEDO	GREEN BAY	MEMPHIS	SALT LAKE CITY	TORONTO
							WINNIPEG, MAN.

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kitchens and — what is very important — to the reception room, where visitors get their first impression of the hospital.

Go into any Univent-equipped hospital and you will be impressed with the efficiency and mental alertness of nurses and attendants. Better record sheets — cheerful patients — and a welcome absence of sickroom odors. New-born infants and patients coming out from under anesthetic are safe from dangerous drafts, for with the Univent there are no drafts.

Write today for our free and interesting book on "Univent Ventilation." It is well worth the careful study of those who are vitally concerned in building and maintaining "better hospitals."



HOW OCCUPATIONAL THERAPY AIDS CHILDREN

By Elsa A. Dudenhoefer, Director, Occupational Therapy Department, Milwaukee Children's Hospital, Milwaukee, Wis.

IN ITS service to childhood, the children's hospital of today is no longer satisfied with the restoration of health by medical treatment, careful nursing and correct diet. It considers the child a charge, for whose mental, moral and social development it is responsible. In taking this attitude, the hospital recognizes the recent advances that have been made in child study and child development, and it has found occupational therapy a necessary adjunct in the administration of the hospital.

Occupational therapy may be defined as some definite task assigned for the purpose of distracting the attention of the patient from his illness, or as a curative agent in the restoration of lost or weakened function by the exercise involved in the making of a wooden toy, in basketry or in textile weaving.

In a children's hospital, however, it has an additional, a deeper and a more intangible significance. It is life; it is play; it is companionship; it develops initiative, perseverance, coordination, self-reliance and it brings joy of achievement—the reward of successful endeavor.

To understand more fully the need of occupational therapy in a children's hospital, let us compare the life of a normal, healthy child with that of the hospital child. The normal child's life is made up of activities concerned with the home, the school and the outdoor life spent among companions of his own age. Dr. William A. White, superintendent, Saint Elizabeth's Hospital, Washington, D. C., in "The Child: His Nature and His Needs," writes that the child is not a small adult. He is exquisitely alert to all that goes on about him and draws his own conclusions.

In another chapter of this book, written by Professor Mary T. Whitley, Columbia University, New York, we

read that play is the child's chief business in life.

The child in the hospital is in an environment totally foreign to his nature. It may be his first experience away from home and from his mother's care. He chafes against the restrictions under which his condition has placed him. Play is still his business in life and he must have some opportunity to use his mind and hands.

Some fundamental reasons why occupational therapy is one of the imperative needs of the hospital child may here be enumerated:

Activity and play are the right of every child. Confined to a hospital his surplus energy must be utilized in some constructive way.

In order to dispel lonesomeness and help him to adjust himself to his new environment, he must be given something to do that will interest him. Very often pegs and a peg board given to a little four-year-old, arouses the first friendly response of smile or conversation.

Occupational therapy aids his mental development by teaching him new projects; it aids him morally by developing self-confidence, will power and perseverance; it aids him socially by teaching him to cooperate with others.

It helps the disheartened patient to "carry on," especially in protracted illnesses such as heart disease, osteomyelitis and tubercular bone diseases. It also aids in the restoration of lost or weakened functions.

At this point, a short history together with a description of the ideals and actual operation of the occupational therapy department of the Milwaukee Children's Hospital, Milwaukee, may not be amiss.

About seven years ago, in November, 1919, the present occupational therapy department was organized by the



Phillips' Milk of Magnesia neutralizes excess acid, thus fulfilling a natural function in cases of hyperacidity.

Hyperacidity—a Vicious Circle

"Phillips' Milk of Magnesia" represents the ideal neutralizing agent in the prevention and correction of acidosis. Meyer and Gottlieb, in "Pharmacology Clinical and Experimental" 1914, state: "The apparent hypersecretion (of the peptic glands), however, is often due to nothing else than an accumulation of the continually secreted gastric juice which, in cases with motor insufficiency and spasm of the pylorus, is not sufficiently neutralized by saliva from the mouth or by mucous from the stomach. (Katchowski.) In this connection it should be remembered that hyperacidity itself has a tendency to

cause spasm of the pylorus." And in this condition "Phillips' Milk of Magnesia" neutralizes the excess of acid and relieves the spasm. "Phillips' Milk of Magnesia" combines therapeutic efficiency with inviting appearance and pleasant taste.

CAUTION

The hospital should insist on "Phillips' Milk of Magnesia" and avoid imitations. The genuine bears our registered trade mark. It is your assurance. Supplied in 4-ounce (25c bottles) and 12-ounce (50c bottles) and 3-pint hospital size obtainable from your druggist or jobber.

PHILLIPS' Milk of Magnesia

"Milk of Magnesia" has been the U. S. Registered Trade Mark of The Charles H. Phillips Chemical Co. and its predecessor Charles H. Phillips since 1875.

THE CHARLES H. PHILLIPS CHEMICAL CO., New York and London

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Junior League under the direction of Hilda B. Goodman. A few boxes of materials placed upon a bed in a cold, unused sun porch comprised its initial equipment and marked its modest beginning. Two volunteer aids, members of the Junior League, worked daily in the wards of the old, two-story hospital building, which had a bed capacity of fifty, Miss Goodman supervising the work once or twice a week. In January, 1920, the present director, a graduate of the occupational therapy course at Milwaukee Downer College, Milwaukee, assisted by the same trained volunteer aids, was appointed.

The work was almost entirely bedside, with the exception of a few convalescent children who sat around small tables in the wards. Even at this early date, prescription blanks were filled by the resident physician, stating the diagnosis and length of time the patient might be given occupation. A daily record was also kept of the patient's work, and upon his discharge this was filed with the medical record.

How the Room Is Equipped

In November, 1923, we moved into our new hospital building, which is equipped to care for 150 patients. The work increased and now extends over five floors of bedside cases and one spacious occupational therapy room. This room is known as "The Play Room." Its very name has an attraction for the hospital child and as he lies in bed waiting for his turn to visit this room, of which his companions have told him, he is filled with happy expectations. Its influence for good extends even beyond the hospital walls. One little patient, a tonsillectomy case, told me one morning, "I was not afraid to have my tonsils taken out. At Sunday school I heard about this room where the children make things to take home. I would rather come to the hospital than go to Sunday school."

Pleasantly located on the third floor, the floor for private patients, the occupational therapy room faces east and has eight windows, two of which are north and one south. Brightly colored chintz shades of bird and flower design adorn the windows. It is equipped with cupboards and tables suitable for the various occupations, such as basketry, weaving, toy-making, painting and kindergarten, and with chairs comfortable for the children of various ages. Two large showcases in which the articles made by the children are exhibited divide the kindergarten from the workshop. In the kindergarten section there are two tables and chairs, a box of blocks and several duck rockers. Drawings, posters and projects in clay, placed upon the bookcases which line the wall, add a note of color. A doll house lighted with electricity is the wonder and delight of the little girls, who find occupation in cleaning and rearranging its furniture.

Occupational therapy deals with the individual, and unlike the school with its graded classes, the groups that come to the play room are small, and are composed of boys and girls of every age, from three to twelve years. They are brought either from the surgical or medical floors, and to lessen contagion they come at different times.

The Milwaukee Children's Hospital is affiliated with the community fund and takes care chiefly of part-pay and free patients. The majority of its patients are acutely ill and remain but a comparatively short time. There are, however, quite a number of heart cases, osteomyelitis and tubercular bone cases. In a hospital of this character, occupational therapy can do little curative work in the sense of restoring lost function, because patients are returned to their homes as soon as possible. Patients needing this sort of treatment after discharge are referred to the curative workshop supported by the Junior League.

That the influence of occupational therapy may be universal throughout the hospital is our ideal and aim. No patient leaves the hospital without having received some service from our department. All books, magazines, games and toys given to the children are carefully selected and distributed by the director and her aids. Holidays, such as Washington's Birthday, Easter, Halloween and Christmas are happy because the children help in the preparations for the celebration. Nor is the birthday child forgotten, for he receives presents and a birthday cake with lighted candles.

During the school year, a teacher from the Milwaukee public schools gives instruction to children who are in the hospital longer than three months. To receive the benefits of an education is another right which the hospital child cannot be denied and the cooperation between the teacher and our department has always been most satisfactory.

There is something to be said on the question of volunteer aids. In my experience, I have been particularly fortunate in having one aid who has worked daily for over four years. Another, a graduate in occupational therapy, substituted during my vacations and worked on consecutive days for several months each year. Aids of this description are invaluable. Aids who wish to work but one morning a week are useful only in playing phonograph music in the wards. This form of amusement is, however, much appreciated and has a specially soothing, quieting effect on young, homeless children.

The occupations given to the children are blocks, peg boards, stringing of wooden beads, paper chains, animal stencils, simple cut-outs, sewing cards and winding of yarn on cardboard to make fluff balls, for those under six years of age. The children over six color pictures and cut-outs, make booklets of animal stencils, sew cards, weave raffia mats and hammocks of twine, sew hot dish holders, embroider towels and stuffed animal toys, make raffia napkin rings, leather shoe polishers, net woven bags and scarves, horse lines on spool knitters, weave neckties and scarves on looms and make wooden toys.

Points to Remember

In giving occupation to children there are several principles the instructor has in mind. The occupation must be simple enough so that success is assured. It must appeal to him because of the bright colors used, because he can play with it or because he may give it to his mother, brother or sister. Articles that can be completed quickly are best. A child's interest cannot be held to one thing for any length of time. Articles begun must be finished so that the child may learn perseverance and feel that his efforts have been rewarded.

Articles of inexpensive material and not salable are given to the children. Of every two or three salable articles a child makes, he keeps one. Although orders are taken for baskets and net woven bags, the patients are never forced to work or hurried because of a sale. To be allowed to work is always considered a privilege.

When I look back over my seven years of experience in occupational therapy, and recall the hundreds of children whose hospital stay has been brightened and made bearable, whose destructive habits have given way to those of construction, the scores of Johnnies who have said, "I have been waiting for you since seven o'clock this morning!" and the scores of Marys who have asked, "Why don't you come on Sundays?" I feel convinced that occupational therapy has become an integral part of the hospital and its value in raising the general morale cannot be over-estimated.

Many physicians are prescribing this fine old ginger ale

*Look
for the name*



*on the bottle
cap*



"Canada Dry" is universally conceded to be the finest ginger ale ever sold in the United States. It has won this place of distinction not only because of its wonderful flavor, but equally because of its unquestioned purity and quality.

"Canada Dry" has been served for years in the leading hospitals in Canada and now is also being served in many of the great hospitals in this country.

The high carbonation of "Canada Dry" makes it of especial value in the sickroom and in convalescence. Remember too that it does not contain capsicum in any form.

“CANADA DRY”

Reg. U. S. Pat. Off.

Extract imported from Canada and bottled in the U. S. A. by Canada Dry Ginger Ale, Incorporated, 25 W. 43rd Street, New York, N. Y. In Canada, J. J. McLaughlin, Toronto and Edmonton. Established 1890.

DOES NOT CONTAIN CAPSICUM IN ANY FORM

(C) 1927

NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

WHAT ARE THE EDUCATIONAL NEEDS OF THE SMALL HOSPITAL SCHOOL OF NURSING?*

By Mary E. Gladwin, Director of Nursing Education, Minnesota State Board of Nursing,
St. Paul, Minn.

IN THE discussion of the many problems pertaining to nursing education on a large scale, in the consideration of the importance and influence of university schools, and in the efforts to promote better teaching, there is a tendency to neglect those institutions that are less fortunate, whose existence is a constant struggle, and whose contributions to nursing education are sometimes far from satisfactory.

That the very small hospital is necessary to the community in which it is located can hardly be denied. In many ways, its importance is out of proportion to its size. Not only is it important from the standpoint of the physician and the patient, but it dominates the thought and action of the community in regard to nursing and nursing education.

Almost without exception, the persons who own or control these hospitals honestly believe that the only possible way to care for their patients is by means of a school of nursing. That is the only reason for the existence of the school. When the school is in difficulties seeking advice and help, we hear the impatient retort, "A hospital of that size has no business with a school, let it do its nursing by means of graduate nurses." An inconsiderate answer of that sort, based on no attempt at reasoning or understanding, is far from helpful and demonstrates our inability to see both sides of a question. When retailed to the community whose interests are served by the little hospital, it naturally creates much irritation, sometimes leading to political opposition to laws or amendments upon which our hearts are set.

Questionnaire Method Is Used

This paper, which does not present a solution but only an introduction to an important topic, is based on a simple questionnaire sent to schools of nursing connected with hospitals having fifty beds or less. Hospitals of fifty beds or less were chosen because institutions having a greater number belong in quite a different class, both as to administration and teaching. The number of beds is unsatisfactory and unreliable as a basis of study, but many of the superintendents do not know how to find the daily average of patients.

*Read at the meeting of the National League of Nursing Education, San Francisco, June, 1927.

Four hundred and fifty questionnaires were sent out and 268 were returned. In each state, a member of the board of examiners was asked to assist. The response to this request was cordial and helpful. A study of the answers is suggestive and it made the writer a little ashamed. Less hurry, more deliberate and thoughtful attention to the wording of the questions, would have brought better results. Just as the questions are faulty, the answers betray the need of greater accuracy of speech, the need of an understanding and agreement as to the meaning of certain words and phrases that we all use. If our words are stumbling and inaccurate, so is our thought, and then, of necessity, that same lack is characteristic of our teaching and of our care of sick people. In any hospital, accuracy and precision of speech are essential. If they are not found in matters of administration and organization, they are usually lacking in the educational department.

The first point upon which information was desired was whether the hospital was municipal, county, state, private, or maintained by a hospital association. Several times a hospital was described as municipal, private and Protestant. A city hospital could not be sectarian, and certainly it is not a private institution. The hospitals mentioned are probably private ones caring for the sick poor for whom the city pays. In many instances a private hospital is confused with one admitting private patients. A church hospital, owned, controlled, staffed by members of a certain church is described as non-sectarian, even when the members of the faculty are required to attend the church in question, because it admits patients of any or no belief.

The use of the words "private" and "hospital association" in the questionnaire was wrong. All hospitals owned and controlled by stockholders who expect returns from their investments, are private, while those which are "incorporated, not for gain," the earnings going into improvements, may be rightfully called community hospitals.

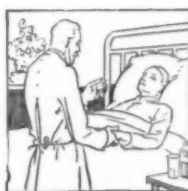
The small hospital is owned by every variety of organization:

Organization	Number of Hospitals
City	16
County	11
Township	1



QUIET

THE peaceful beauty of the countryside is mirrored in its placid lakes. The soothing restfulness of the quiet hospital is reflected in the faces of its patients.



Johns-Manville's method of acoustical correction will quiet any hos-

pital, old or new. By subduing the unavoidable noises of hospital activity it brings greater comfort to your patients, and hastens their return to health.

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Fraternal	2
College	1
	<hr/> 268

The daily average is given as being from 18 to 25 or from 20 to 40, which, naturally, it cannot be, any more than $2 + 2 =$ from 4 to 10, or $5 + 6 =$ from 11 to 30. A daily average is a mathematical certainty, and when not otherwise specified, it should be understood that, in any study, the daily average required is for one fiscal year.

Daily Average	Number of Hospitals
5-10	7
10-15	25
15-20	50
20-25	51
25-30	41
30-35	35
35-40	15
40-45	15
45-50	7

The monthly average of major operations gives us some clue to the amount of clinical material available for teaching purposes. Minor operations in the very small hospital are usually for enlarged tonsils and adenoids. The number of medical patients is usually at least one-third less than the number of surgical patients. Often two-thirds of the patients admitted are surgical, the number of maternity patients being much less than the number of medical.

Monthly Average of Major Operations	Number of Hospitals
1-5	9
5-10	12
10-15	35
15-20	43
20-25	31
25-30	17
30-35	23
35-40	13
40-45	12
45-50	2
50-55	4
55-60	3
60-65	3

The question as to the segregation of beds is answered thus:

Not segregated	159
Segregated	31
Obstetrics only	31
Partly	28

Departments

Pediatrics	45
Tuberculosis	4
Contagious	21
Nervous and Mental	8

These departments are sometimes represented by one bed and are usually, in hospitals of this class, from two to six beds. By the pediatric department may be meant two small beds in a general ward. The answers in regard to segregation are, unintentionally, far from reliable because they mean that a number of beds is set aside to be used for a certain purpose if possible. The exceptions are so many and so constant that the segregation does not exist except in intention. In this connection, in the 219 hospitals in which the services are not segregated, case records are kept by 126 schools and 89 keep none.

Even now in many instances, and in institutions where there are only three services—surgical, medical, and obstetric—little attention is paid to the necessity for a varied experience. If the chief surgeon is pleased by the work of a nurse, she remains in the operating room for a year or eighteen months. Even in this year of grace, she sometimes stays in the diet kitchen indefinitely, or her record shows that she has spent the equivalent of sixty-six days in the office on Sundays and odd afternoons, or two months in the drug room washing bottles, all this in the name of education. The scarcity of applicants for a number of years helped somewhat in the correction of some of these things. Now that applicants are becoming more and more plentiful, we must guard against the return of some of these undesirable methods. However, it is only fair to say these things are found in many much larger institutions, and found oftener than is generally supposed.

After all these years, it is pertinent to emphasize the statement that complete records are necessary and that, once made, they are the property of the school, not to be altered or changed at the pleasure of the superintendent of nurses.

The Superintendent of the Hospital

A lay person	6
Doctor	30
Sister not a nurse	6
A minister	4
A nurse	216

The public is slow to realize that the fitness of a person to administer a hospital has no relation to nursing, medicine or the ministry. The nurse naturally knows more about hospital life than the other two but few things have done more harm than the general belief that any graduate nurse is qualified to organize and manage a small hospital simply because she is a graduate nurse.

In 166 hospitals the same nurse is superintendent and superintendent of nurses. For several years the writer has studied this combination of offices with a good deal of care, and she has, moreover, tried it herself. She is convinced that there could be no worse arrangement. The superintendent is held responsible for lessening the hospital debt or, at least, for not incurring or increasing a deficit. Added to this is the necessity of pleasing the doctors, who should be pleased and considered. The most honest and well intentioned nurse in the world often finds it impossible to do justice to the school under the circumstances. Her attention may be called to the inadequate housing facilities for the students, the condition of the bathrooms, the lack of hot water, the paucity of teaching equipment. Her answer is "Yes, we know something should be done. In a few years we mean to build, but we cannot afford anything better now. You know we have a debt."

Any psychologist will tell you that this superintendent's anxiety and determination to do the best she knows how for the institution, often prevents her from realizing how money might be obtained for the needs of the school. She is right about the hospital. It is enough of a job for

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one woman, but there should be in the school another person who is determined to change conditions. It is difficult to convince a superintendent and the trustees back of her, that the living conditions of the school often contradict all the teaching of hygiene, sanitation, and positive health and that such contradiction has as much bearing on the success of the hospital and the care of the patients as the reduction of the hospital debt, and that it sometimes prevents that reduction.

In 191 hospitals the medical staff is organized, in 66 it is not; 108 report having a training school committee and 146 have none. It is evident from the answers to the questions that many of the superintendents do not know how to use such a committee. Often we are told that there is nothing for such a committee to do. What the committee does matters little. What counts is what happens to the committee in the way of education and enlightenment. The wise superintendent of nurses keeps her school committee well informed as to what is going on in the nursing world. She sees to it that the members read nursing publications. The committee should serve as an intermediary between the school and the public, and sometimes it is able to change the sentiment and feeling of the entire community as it grows in understanding and knowledge. Some of its members should be well known in civic and social activities. Its usefulness is much limited if they are all on the hospital or the medical staff.

Much may be done by suggestion or implication. Suppose that as a matter of news concerning one of the things that nursing organization has brought about, the committee is told of the Nurses' Relief Fund, the amount of money that has been collected and the number of nurses who have been and are being helped. A little later the committee may hear that there is, apparently, an increasing number of young nurses graduated only a few years ago, applying for help because they have contracted tuberculosis. Still later, the committee is shown the crowded condition of the nurses' home. The youth and immaturity of the modern student of nursing should be constantly kept before the committee. They will soon discover that in caring for the sick in the hospital, they may be responsible for other sick people who will need care in a few years. If the members of the committee do not recognize the steps by which they have been led to these conclusions that is of no consequence, and sometimes more can be accomplished in that way.

19 hospitals report employment of 1 graduate	
58 hospitals report employment of 2 graduates	
51 hospitals report employment of 3 graduates	
58 hospitals report employment of 4 graduates	
23 hospitals report employment of 5 graduates	
10 hospitals report employment of 6 graduates	
18 hospitals report employment of 7 or more graduates	
Graduate night supervisor	164
No graduate night supervisor	92
Superintendent of nurses on call at night	84
Graduate operating room supervisor	191
No graduate operating room supervisor	64
Superintendent of nurses manages operating room ..	79
Superintendent of nurses gives anesthetic	41

Some hospitals admit quite frankly that the superintendent is superintendent of nurses, housekeeper, dietitian, is on call at night, gives the anesthetics, has charge of the operating room, and does all the teaching except that done by the doctors. In many hospitals, something like this is found. Three graduate nurses are employed, one of whom is the night supervisor. The nurse who is superintendent

and superintendent of nurses, admits and discharges the patients, makes out and collects the bills, supervises the laundry, does the housekeeping, including the buying, sees the patients' friends, answers the telephone when free from other duties, waits on the doctors, looks after the records and the bookkeeping, gives the anesthetics and does some of the teaching. The assistant takes over the work of the superintendent when the latter is absent, has charge of the operating room, scrubs for practically all major operations and does most of the teaching. Changes occur so frequently that the nurses carrying such loads of responsibility are often young graduates, of two or three years standing at the most, and who have had no particle of preparation for the work they are doing.

Four or five mornings a week, the operating room is busy. The senior nurses are away for their affiliation. During the busy morning hours, when important treatments are to be given, doctors waited upon, and the heavy work of the day done, the responsibility falls upon very young shoulders, students who work day after day and week after week with little supervision.

The superintendent is late for luncheon, telephone numbers have been left for her, there are patients to be admitted or discharged, bills to be made out, supplies to be ordered. The janitor, the cook, the laundresses are waiting to consult her, it is time for the students to begin to take their afternoons or hours off, three o'clock is rapidly approaching when the harrassed and worn woman is supposed to teach a class in ethics or professional topics, and as soon as possible she must give a test in metabolism or take an x-ray picture. Your whole heart goes out to her, all the more because she often does not realize her limitations. She has had no scrap of preparation in administration; hospital equipment; purchasing of supplies; management of kitchens, storerooms and laundries; the employment and control of servants; bookkeeping; record keeping; school organization; teaching.

Each one of these is a business in itself, requiring time, thought and preparation to carry on effectively. One wonders sometimes how the organization hangs together. It would not do so were it not for the innate goodness and helpfulness of human beings.

Number of Pupils	Number of Schools
2 to 5 pupils in	3 schools
5 to 10 pupils in	67 schools
10 to 15 pupils in	96 schools
15 to 20 pupils in	54 schools
20 to 25 pupils in	33 schools
25 to 30 pupils in	9 schools
30 or more pupils in	6 schools

A fair number of the very small schools have graduated only one class. Thirty-five have not yet graduated any. In 1923, 557 were graduated; in 1924, 668 were graduated and in 1925, 769 were graduated, making a total of 1,994.

One would like to know what has become of these approximately 2,000 pupils and especially how many of them are now in charge of small hospitals and schools.

One hundred and seventy-four schools reported plenty of applicants; fifty-eight that there were not enough. Here again, in many instances, no distinction is made between the young woman who writes a letter of inquiry, usually to several schools, receiving a blank in return, and the real applicant, who fills and sends back the blank thus applying for admission.

The report of the educational requirement is as follows:

Completion of the eighth grade	2 schools
Completion of one year of high school	108 schools
Completion of two years of high school	87 schools

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couraging glow, it has a psychological effect that no doctor or nurse should fail to recognize. In many cases, CLICQUOT CLUB Golden is retained when all other food or drink has been rejected.

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Completion of three years of high school 1 school
 Completion of four years of high school 56 schools

It is sometimes difficult to make the young student who says her educational requirement is two years of high school and who admits that there are exceptions in every class, understand that one year of high school is her requirement and two years the goal towards which she is striving.

In connection with the minimum educational requirement for admission, more attention should be paid to the amount of education necessary for a superintendent or an instructor. It seems reasonable to expect that every member of the faculty should have at least the minimum requirement for students. The speaker knows several schools having a minimum high school requirement whose superintendents have only a common school education.

We should not only drive home the necessity of special preparation for any work undertaken in our classes in professional problems but, in our ethics, we should teach that such preparation is an obligation and a duty. It is idle to say that four or five years of experience compensates for such a lack. It does not.

Age Requirement

18 years	227 schools
18½ years	1 school
19 years	17 schools
20 years	3 schools
21 years	1 school

One of our Minnesota schools has gradually increased its age requirement to nineteen and one-half years with no apparent decrease in the number of its applicants. The result in the life of the school is marked. Fewer days have been lost from slight illnesses, and, in addition, the pupils show greater stability and better judgment.

The teaching of dietetics is often a clue to educational conditions.

Dietetics Taught By:

The superintendent	94 schools
A doctor	7 schools
A dietitian	76 schools
In a high school or college	53 schools

Occasionally the teacher is a visiting dietitian or one who is married and lives in the town. Sometimes the so-called dietitian is just somebody who somewhere and at sometime has had some connection with food. Dietetics in a high school or college means laboratory work, but it needs rather careful supervision. The tendency to emphasize fancy dishes and candy making needs suppression. More emphasis should be put on simple, nourishing dishes, which are palatable and appealing.

A school without a classroom seems to be an absurdity but it is not unknown.

Classrooms

Room used for no other purpose	187
None	62

It is interesting to note what other rooms are used for this purpose:

Reception rooms	18
Libraries	2
Serving rooms	2
Offices	5
Sterilizing room	1
Chapel	1
Accident room	1
Dining room	21

The dining room seems to be a favorite substitute. The writer has seen it so used in at least four states. There is nothing more disheartening to one who loves the proc-

esses of education, than to see student nurses assembled for class around a table already set for breakfast, with their books, and, possibly, their elbows in the breakfast plates.

Demonstration rooms	108
Skeletons	202
Dolls	167
No blackboards	3

What can be the state of mind of a teacher who tries to prepare students for nursing without classroom, skeleton, doll, blackboard, charts or any affiliation? We are so apt to forget about the influence of the unconscious teaching of an institution. Tired bodies and tired minds react unfavorably to unsuitable surroundings, and those surroundings often make futile the eloquence of the teacher. A room, however crude, which proclaims itself a classroom, is essential, blackboards may be painted on the walls, a doll which is homemade has advantages, and there is always a doctor who is ready to loan a skeleton or a few bones.

Earnest effort has been made for many years to give the student an understanding of the gospel of health and of her obligation to teach it by word and example. One wonders why the reiterated lessons are like seeds fallen on stony ground. One has only to read registration examination papers to realize that the truths that we consider vital are mere fluff to the student. They are in no way a part of her life and thought. May not at least a partial answer to the puzzle be found in the way the school life denies its own teaching? We insist, for example, that food should have closely thought out relation to our nutritional needs, that it should be served daintily, that it should make an appeal to the eye. A scientific study of the food served to pupil nurses in hospitals, big and little, and of the sort of service provided would help us to understand our many failures.

There are probably few teachers of personal hygiene who do not advocate the daily bath as a measure of protection, comfort and self-respect. There are scores of schools where it is not even remotely possible. Sometimes a bathroom is reserved in the hospital for the school, reserved for as many as twelve people in which to undress, bathe, re-dress, and then go across to the home to undress again and make preparation for the night. Such a method is prohibitive wherever the bathroom is situated. The bathroom contains the tub, toilet and wash-basin, none of them screened, and it must meet the needs of from six to twelve persons, the number oftener twelve than six. Is it possible for them to obtain a bath and prepare for the night with any privacy or decency? Many times a complaint has been heard that two students bathe together in the same tub. Disgusting, indecent? Possibly, but there is something underneath more important than the dual bath, something worth thinking over and which should be heeded.

In the morning the pupils stay in bed until the last minute and they must be at breakfast by 6:30 a. m. In less than thirty minutes, they are supposed to wash, at least their hands and faces, to clean their teeth and attend to their bodily excretions. No privacy, no reticence, no decency possible, no remotest chance of forming correct bodily habits.

What have conditions such as those described to do with education? They are an important part of our educational process and they present one of the most potent causes of failure. Our living conditions emphatically deny the truths we teach. The lack of proper hospital provision for the care of the hands proclaims aloud the futility of much of our instruction in bacteriology; over

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three thousand unbalanced, untidy meals make of no avail what is taught in dietetics. As an educational method, as a preparation for work in which ways of living count tremendously, it is extravagant beyond words.

Great improvement is seen in the time set aside for class and lecture work.

In the Evening	Schools
All	23
None	41
1/10	21
1/4	21
1/3	41
2/3	30
1/2	64

One superintendent wrote, "I try to get in all the class work in the evening after seven."

Hours on duty per week:

Hours	Schools
40-45	3
45-50	26
50-55	71
55-60	62
60-65	64
65-70	8
70-75	2
90-95	1

Affiliations:

Number of Months	Schools
2	3
3	18
4	22
5	6
6	36
7	1
8	11
9	8
10	1
12	20
	126

With the increase in the number of applicants has come difficulty in obtaining affiliation. In many states it is well-nigh impossible to obtain it for pediatrics and infectious diseases.

It should be encouraging to the young ambitious members of the National League of Nursing Education to realize how much opportunity remains to them for hard, earnest work and straight, clear thinking about nursing education. Dr. Henry S. Pritchett once made the following criticism, "The most striking weakness of American political and economic thinking lies in the superficial character of our education. In our public schools and no less in our universities and colleges, education is interpreted only too often to mean a smattering of knowledge in many things; seldom is it construed in terms of the mastery of any one subject or as the ability to think clearly." If Dr. Pritchett dared to express so emphatically and courageously what he believed about education, surely we, in the same spirit, may say what we believe. Well, then, I believe that today, in the present stage of the increase of our population, the small hospital is as necessary and important in its place as the university or big city institution, I believe that the educational opportunities it offers have been underestimated and neglected, I believe that it is the duty of the National League of Nursing Education to study its problems with the same interest and careful thought now being given to university and big schools of nursing.

Before we go far we must clearly define general nursing

education and education in specialties. Have we given sufficient thought and valued aright those intangible influences that are necessary to produce the well bred, well mannered, well poised young women necessary for the development of the good nurse? Have we really correlated our theory and practice, either in our work or in our thought? In this respect aren't our examinations for registration misleading and rather absurd? Isn't it unsound reasoning or lack of any reasoning that leads us to make registration dependent upon two and one-half days spent in writing answers to questions? Just as a man may know French grammar, and yet be unable to write, read, or speak the French language, so an applicant for registration may be on the honor roll and still be a wretched, untrustworthy nurse. Worse even than that is the psychological effect of proclaiming to the pupils, the hospitals and the public generally, that it is only the theory of nursing that really counts. The theory should be the wholesome firmly rooted plant on which blooms the practice of nursing, the beautiful flower of conscientious and devoted care of sick people.

If the nursing education of each state were connected with the state university or with the state department of education, would not our standing be improved? Isn't it time that we took boards of examiners of nurses out of the field of politics and gave them a sound educational background?

A normal school in every state, given over wholly to nursing education, connected with a state university or under a state department of education, having a central school whose pupils were assigned to hospitals, big and little, would be valuable. A general nursing education as a foundation for all nurses, and, in addition, theory and practice in organization, administration, supervision, and teaching, with intensive work in other specialties for those who desire them, combined with a requirement that all superintendents of nurses and instructors of accredited schools, must have successfully taken the courses necessary for their work, would go far to remedy some of our difficulties.

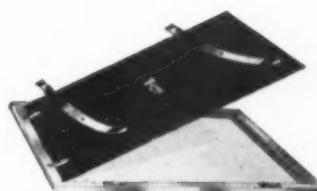
No unsuitable condition exists in the small school alone. A similar condition can always be found to match it in a large school, and the small schools offer wonderful opportunities for practice in supervision and teaching. The sick person in the rural community is entitled to as good scientific care as the one in the large city, and the only way to give it to him, aside from the use of graduate nurses, which has been usually unsatisfactory, is to make the institution a part of a great teaching system. If we went a step or two further, strengthening the work by frequent inspection, giving standardized examinations at the end of each year, requiring a definite amount of equipment, and allowing graduation from these accredited schools to mean automatic registration, it would be a splendid achievement. Our present educational system is unsound because we separate the university and big schools from the little ones and then register the graduates of all of them on the same artificial and false basis.

NURSES HOME AT SAYRE DEDICATED

The new nurses' home of the Robert Packer Hospital, Sayre, Pa., was dedicated May 25, the day of the twenty-third annual nurses' commencement. An interesting program was presented and an address was given by Dr. Wilmer Krusen, director of public charities and hospitals, Philadelphia, who was introduced by Dr. Donald Guthrie, Sayre, Pa.



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WHY WE OWE THE NURSE COMMUNICABLE DISEASE TRAINING

By Charlotte Johnson, R.N., Superintendent, Durand Hospital of the John McCormick Institute for Infectious Diseases, Chicago

THE necessity for communicable disease training for each student nurse is self-evident. The nature and universal prevalence of communicable diseases calls for an intelligent knowledge of the methods of dissemination and an acquaintance with the technique of control.

The very term "communicable" implies a health problem of major significance. Every nurse should be a public health nurse. We no longer feel that she has given the highest type of service while caring for the sick unless at the same time she has been able to carry on preventive measures and do effective health teaching. Preventive medicine and the teaching of positive health is the new gospel of hope for the physical welfare of the race.

Are we giving the nurse a sound basic curriculum which gives her the fundamental background necessary for effectual work in this program? How is the average nurse of today prepared to meet the usual calls for nursing service at the end of her period of training? Has she had a well balanced experience in the actual bedside care of the various types of disease common to every community? Is she equally well prepared to care for the medical, surgical or obstetrical patient and to establish and teach practical, efficient isolation measures, and give intelligent nursing care to the patient suffering from tuberculosis, scarlet fever or diphtheria? These are searching questions that need to be faced squarely by all who are interested in or in any way responsible for the preparation of the nurse for service to society.

Is the Nurse's Training Adequate?

Physicians, hospital superintendents, directors of nurses and public spirited members of hospital boards are awakening to a sense of vital responsibility for public health welfare and are beginning to be disturbed by an uneasy feeling about the clinical experience of the nurse, but in spite of a growing sense of duty they too often pursue a short-sighted policy in their failure to offer adequate preparation for a neglected type of nursing service that is needed everywhere.

Difficulties both real and imaginary have stood in the way and frustrated this important phase of the preparation of the great majority of student nurses who are going out from our schools year after year. Fear is the first stumbling block in the way. The very nature of communicable diseases has throughout the history of mankind inspired terror, but in the light of the scientific knowledge we now possess this former dread should disappear. As a matter of fact, with proper supervision the student is safer in a hospital for contagious diseases than in a crowded street car. After she has acquired an aseptic technique she is in less danger in a hospital for this class of diseases than in the wards of the general hospital where sepsis is not observed.

Suitable arrangements for affiliation with hospitals caring for communicable diseases presents a practical problem. Municipal hospitals with their great wealth of clinical material offer an ideal field for study and experience, when adequate teaching facilities and supervising personnel are available. These great laboratories for

bedside instruction will open their doors to students whenever schools for nurses are ready to take advantage of the educational facilities they have to offer. Research hospitals offer a limited number of affiliations in most large cities. Such hospitals are essentially teaching institutions where case study is pursued and where intensive work in theory and practice can be closely correlated.

By careful planning of class schedules students from neighboring hospitals can take advantage of the teaching and experience to be gained in such institutions and not have the home school schedule of class work seriously interrupted. In smaller cities where the general hospital meets a real community need, there is also quite as urgent a demand for a department devoted to the care of communicable diseases. By the observation of medical asepsis in such institutions the student nurse should have valuable experience in the care of general medical and acute infectious diseases in the same department.

Some Problems Involved

Objections to an affiliated service are often made on various grounds. Some of the problems involved are housing conditions, recreation, educational standards, discipline and interruption of the home school class work. A shortage of students is a frequent objection, which is an open admission of the exploitation of the nurse. Each student is entitled to the best possible preparation for her future usefulness. Her education should not be sacrificed to the hospital needs. Such a dangerous and short-sighted policy is disastrous to the nurse and the patients.

These various problems will be solved when hospital executives and members of training school boards realize the significance of a more thorough preparation of the nurse for this type of service. In view of the far-reaching consequences for good or ill a practical program needs to be worked out, which will result in better preparation of the nurse, more skillful care of the patient and greater safety to the public. Viewed not only from the humanitarian aspect but from the economic standpoint as well such a program is based upon a sound public policy.

Experience Is Essential

Let us look at the situation as it exists today. Comparatively few nurses are actually receiving bedside instruction in the care of communicable diseases. Most of them are given some theoretical teaching in this branch of nursing which is of more or less value. But we will all agree that theory without practice can never make a good golf player. You must get into the game and learn by experience. And in no other way than by experience can the nurse master the art of medical asepsis.

We have tried to ease our consciences by saying that communicable disease nursing is a specialty, and that the nurse who desires to prepare for this type of service should fit herself by taking postgraduate work in an institution caring for acute infectious diseases. But is this branch of nursing any more a specialty than medical or surgical or obstetrical nursing? In the average home does not the incidence of contagion among children rank

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PHOR-US is delivered in all parts of the United States, Mexico and Canada—we wish to make connections with reliable hospital dealers and jobbers.

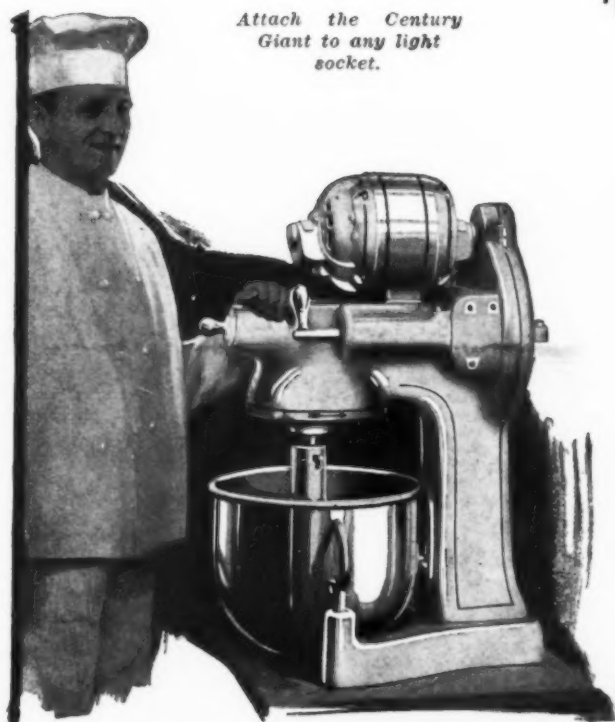
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higher than is the case in almost any other type of illness?

How does the present policy affect the young, inexperienced graduate nurse just out of training? She has completed the course we have offered her, she holds our diploma testifying to her ability and efficiency in the care of the sick. What does the public have a right to expect of this young woman? She is not a specialist at the end of her three years' work, but is it not our duty to see that she has a sound, fundamental basis that prepares her to meet the average daily needs of any patient in the community?

Can the Nurse Meet an Emergency?

She is usually advised to enter the field of private duty nursing, which offers her a wealth of valuable experience, before taking up any highly specialized type of service. She may, for example, respond to a call to care for a patient suffering from acute tonsillitis. Within a few days a diagnosis of scarlet fever or diphtheria may be made. If she has not previously had the bedside care of such diseases under careful supervision is she ready to meet the various problems involved in such a situation? She is frequently unprepared to protect herself from infection, unqualified to deal intelligently and practically with the problems involved in efficient isolation, unable to teach the patient and his family how to prevent the spread of disease, inexperienced and unable to give the best type of nursing care to the acutely ill patient, whose life may depend upon technical skill acquired only by careful teaching and experience.

On the other hand, her classmate who has had actual bedside experience in the care of these diseases should be quick to recognize early typical symptoms, and not only promptly report to the physician the familiar advancing clinical picture developing before her but should be ready to establish immediate efficient isolation of the patient in order to prevent the further spread of the disease. By simple medical asepsis she may safeguard other members of the family, preventing direct or indirect contacts pending diagnosis, with little interference in the household routine. She is thus able to make an intelligent contribution to the conservation of child welfare and also to the program of preventive medicine.

Nurse's Safety Demands this Training

The nurse who has not had communicable disease training often refuses to care for patients suffering from this class of diseases. She is severely criticized for taking such an unprofessional attitude. Before judging this young woman too harshly let us look at the situation from her point of view. Again and again a sister nurse who has accepted such a call has contracted disease from her patient. This has worked great hardship not only in loss of time and in material sacrifice during her illness, but has meant physical suffering followed by a more or less prolonged period of convalescence sometimes resulting in impaired efficiency, ultimate physical handicap or even in death. Is it fair to send a nurse out of her training school expecting her without careful preparation to expose herself to this class of diseases? Who is to blame because she is not ready to take up such a task with confidence, safety and efficiency?

Occasionally a nurse refuses to care for the isolated patient because of the antiquated methods imposed upon her by health department rulings, which are greatly in need of revision. As long as these rulings deny her the right to scrub up, put on clean clothing and go out of doors for fresh air and recreation, she can hardly be blamed for refusal to go into "solitary confinement." In

the past when the methods of the spread of disease were not understood, strict quarantine measures seemed necessary, but with the knowledge available today the well informed nurse, experienced in medical asepsis, should be able to come and go as freely from the isolation area as the nurse who is serving in any other capacity. When nurses are prepared to carry out and to teach medical asepsis, and members of health department boards are confident that simpler methods of isolation will be carried out efficiently, better results can be expected. Incidentally there will be a greater willingness on the part of all concerned to cooperate in necessary isolation procedures.

Although much has been done in the way of lessening the incidence of communicable diseases and mitigating the suffering they cause, they are not likely to be banished from the face of the earth. The intelligent working out of the complex problems they present is the only sensible course to pursue. When we are ready to consider medical asepsis as seriously as we do surgical asepsis a long step in advance will be made. When all medical students as well as all student nurses have a suitable term of careful clinical experience under proper guidance, in wards for communicable diseases, just as they now have in other important departments, then and not until then can we expect real efficiency in the isolation and care of this class of diseases.

Every branch of nursing calls for special technical skill, and if the welfare of the patient and of the public are to be conserved the standard curriculum of our schools for nurses must include both theory and practice in this important branch of nursing. Too long we have adopted the ostrich-like policy of closing our eyes to a type of preparation that we owe to every nurse, whose function today is as essentially that of teaching and conserving health as of caring for the sick.

ADVOCATES LONGER STAY FOR SANATORIUM PATIENTS

Since business concerns find that unnecessary turnover is a wastage on the investment, the same attitude should be taken in the management of institutions, such as sanatoriums, representing large sums of public money, believes Godias J. Drolet, statistician of the New York Tuberculosis and Health Association.

An institution dealing with human lives should surely not have any lower standards for its management than common business projects, in Mr. Drolet's opinion. It would be better, considering the great investment in tuberculosis institutions and the great number of patients needing treatment, to have fewer of the wasteful short-term admissions and more real work with the patients who stay.

Tuberculosis sanatoriums serve the public along three main lines: education of the patients in caring for themselves and protecting their families and associates; cure of the patients, or if this is impossible, humane care; and protection of the community by segregation of the foci of infection. If these institutions are to serve only the educational function, then they should be organized to give intensive training in hygiene and correct living, such as can be given in a short time.

If, however, they are to serve primarily for the cure and relief of the patients, their methods must undergo a change, for in many institutions the patients do not stay long enough to receive definite benefit. This is costly, for the improvement of the patient depends on the length of time spent in the institution following treatment.—*Hygeia*.



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To Pacific Sheets has been added Pacific distribution service. Stocks of the standard sizes of Pacific sheets, pillow cases and sheeting are carried by leading wholesale merchants in 35 key distributing centers—available for immediate delivery. This new Pacific Service is offered by these progressive wholesale distributors:

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DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.

VEGETABLES HAVE "ARRIVED"

By Elizabeth Emmons,
New York

GOOD strong bones, firm fingernails, a healthy head of hair, sound teeth, and a plentiful supply of blood are all results of a balanced diet rich in minerals. Of the minerals used in the body, the ones giving us most concern are calcium, iron, and in some localities, iodine, since the others are usually present in sufficient abundance so that we do not suffer from a deficiency.

Vegetables are beginning to come into their own. The continuous propaganda in their favor is taking effect, as is notable in the increasing number of vegetable dinners offered in restaurants, in the articles on the value of the use of vegetables in the diet, and in the work done in nutrition classes to induce the use of more of these valuable articles of food.

Since the importance of nutrition has been recognized classes or clubs are being formed in many schools to further this work. Vegetables receive their share of attention. It is regrettable that a number of vegetables do not enjoy the popularity they deserve. "Much has been said," remarks one authority, "as to the propensities of bread crusts for making curly hair, but there has not been so much publicity about the influence of spinach, carrots and nearly all vegetables upon clear complexions, strong, even teeth, and smooth edged fingernails."

Vegetables are given their high place in our regard chiefly because of their mineral and vitamin content, and they should be used twice a day, with green vegetables four or five times a week. As knowledge of their value becomes more widespread, questions as to the most simple ways of cooking them become frequent.

Steaming Replaces Boiling

Some time ago a doctor wrote to the New York Herald-Tribune Institute and asked if we could give him a timetable for the steaming of vegetables. He said that since the importance of vegetables in the diet was receiving recognition, people were beginning to take more interest in the proper way to cook them. Boiling has been the time-honored method, but like many other time-honored methods it is now taking a "back seat" in favor of newer means, such as steaming and waterless cookery.

Experiments were carried out, and a table was compiled. It is, of course, impossible to give hard and fast rules in any case, for the age of the vegetable, its freshness, and so forth, make a great difference in the length of time necessary for cooking it. The amounts used in

compiling the table were for the average family. For larger quantities, the cooking time would have to be increased:

Vegetable	Amount Purchased	Quantity of Water	Min. of Boiling	Min. of Steam'g
Asparagus	1 bunch	3 cups	20-30	25-35
Beans (string)	2 pounds	1 quart	30-45	35-50
Beets	2 bunches	1 quart	30-50	50-60
Cabbage	1 small head	3 cups	20-40	30-50
Carrots (sliced)	1 bunch	3 cups	10-30	10-15
Cauliflower	1 medium head	1 quart	15-30	25-35
Onions	1 pound	3 cups	25-40	35-50
Peas	1 pound	3 cups	15-25	20-35
Spinach	2 pounds	2 cups	15-30	20-35
Squash	1 medium	3 cups	15-30	20-35

It is now customary to find offered on every restaurant menu a vegetable dinner or "vegetable plate." A few hospitals have served a vegetable meal once a week with success. For those on house diet, this affords a welcome change, since the vegetable meals have color and brightness, which adds so much to the appetizing appearance of a tray. Books on cookery now give combinations of vegetables and in one book of menus the following good suggestions were made:

Vegetable Plate Meals

1. French artichoke, hollandaise sauce in lettuce leaf, mashed potatoes, buttered beets, mashed turnip.
2. Diced carrots, beets in butter, mashed potatoes, asparagus, spinach.
3. Baked green pepper stuffed with Spanish rice, beets, stewed celery, string beans.
4. Broiled summer squash on toast, butter sauce, spaghetti in tomato sauce, peas, carrots.
5. Boiled young onions, spinach, grilled tomatoes, riced potatoes.
6. Corn-on-cob, stewed cucumbers, grilled tomatoes, stewed eggplant and okra.
7. Salsify in butter, Spanish rice, tomato and cheese grill, peas.
8. Fresh broiled mushrooms on toast, Brussels sprouts, creamed potatoes, grilled tomatoes.
9. Cauliflower, hollandaise sauce, string beans, baked potatoes, beets.

What were once called "unusual vegetables" are now becoming more familiar. Markets, which a few years ago had never heard of artichokes, okra, or broccoli, are now carrying these vegetables, and even making a feature of them. As more vegetables are consumed, the demand

For any diet where starch is allowed ~this tempting vegetable dish

Corn and Cereal Timbales

1½ cups cooked Cream of Wheat
1½ cups cooked corn
2 tablespoons melted butter
3 eggs, beaten
Salt and pepper

Mix Cream of Wheat with the other ingredients. Bake in cups, surrounded by water, till mixture is firm.

PATIENTS whose appetites need the stimulus of variety, but whose diets exclude many dishes on the regular hospital menu—their is a problem with which every dietitian is familiar. For help in the daily solving of it the dainty dish given above will find favor.

Such dishes break the wearisome monotony of special diets and at the same time meet the requirements of doctors' standing orders. A wide range of them—all tempting, all nourishing—may be easily made with Cream of Wheat. For every patient, except the comparative few who have disturbances where all starch is eliminated, can eat Cream of Wheat in some form.

Physicians have endorsed it as a hospital food for thirty years. They want the nourishment that its high starch content gives, and they want that nourishment without digestive tax. The simple, granular form of Cream of Wheat insures easy digestion.

Dietitians welcome its uniform quality—never varying year in and year out, its triple-wrapped-and-sealed package, shutting out all contamination, and its economy.

The recipe given above comes from the free recipe booklet, "50 Ways of Serving Cream of Wheat." This booklet is full of valuable suggestions for cereal combinations, with vegetables and as desserts. Send for it.



FOR THIRTY YEARS A STANDARD FOOD ON
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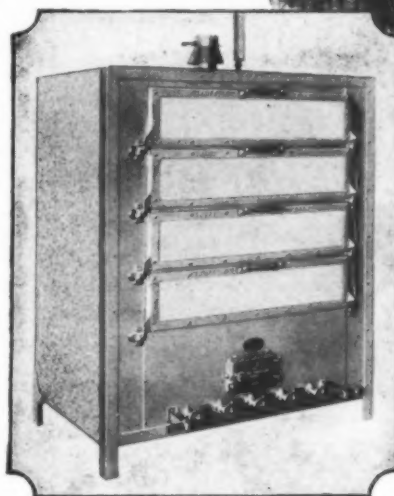
Cream of Wheat

Cream of Wheat Company, Minneapolis, Minn.
In Canada, Made by Cream of Wheat Company, Winnipeg

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Early California Indians put seeds and hot coals together in a basket and shook continuously until seeds were baked.

No. 2 in series on Evolution of Man's Diet.



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THRIFT
Gas Oven

But Methods Have Changed with Diets

TODAY the carefully prepared baked foods of the hospital require uniform baking.

Thrift Ovens, because of unique construction features, assure more even baking on every deck. The greatest advancement in fuel economy has also been realized in the unique construction of the portable Thrift Gas Oven. Thorough distribution and complete utilization of heat is the reason for the more uniform baking and greater fuel economy obtained with the Thrift.

The clean, compact Thrift Oven recommends itself highly for hospital use where sanitary appearance and economical operation are desired.

Let us show you how the "Thrift" method of baking at "retained heat" will improve your baking and cut your costs. Send for Bulletin N.

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New York District Sales Office will be maintained at 100 Grand Ave., New York.

The Surface Combustion Co.

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Branch Offices in All Principal Cities
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for something different leads to branching out, both in the markets and in the field of cooking. More ways of preparing our commoner vegetables are constantly being introduced while the newer ones are also becoming the basis of culinary experiments.

The problem of introducing into the diet vegetables that are not well liked has resulted in several recipes. To give but one example, vegetables that are liked may be stuffed with others that are not so popular. Squash, eggplant or tomatoes may be stuffed with a mixture of whole wheat bread crumbs, a little beaten egg or milk and some other vegetable. Cover the top of the stuffing with buttered crumbs and brown.

Cream soups and vegetable soups offer another method of increasing the number of vegetables in the diet. Salads are gradually getting in the class of "best sellers" in restaurants and cafeterias, especially during the summer months, which is a hopeful sign since green vegetables should be included in the diet at least four or five times a week.

When a change is desired from the usual vegetables, there are several less common ones that may be served in a great variety of ways. The globe or French artichokes are now to be found in most markets. To prepare them, remove the withered outer leaves and several layers if they feel hard. Cut the stems even with the leaves, straight across. As fast as prepared, drop each artichoke into cold water containing two teaspoonfuls of vinegar to each pint, to prevent discoloration. Before cooking, drain and wash in running water to remove the vinegar flavor. Prepare one small or half one large artichoke for each person. Artichokes that have been boiled, steamed, or broiled may be served with a variety of sauces such as hollandaise, tartar, cream, or bechamel, or simply with melted butter.

Steamed Artichokes

Prepare artichokes as directed above. Dust with salt, place in a steamer and steam until tender—from forty minutes to one hour according to size and tenderness. If very large cut the artichoke in half, lengthwise.

Stewed Artichokes

3 large globe artichokes	$\frac{1}{2}$ cup veal or chicken stock
$\frac{1}{2}$ cup butter	Salt and pepper
Juice 1 lemon	Buttered toast

Prepare the artichokes as directed. Quarter and par-boil for ten minutes; drain and fry gently in the butter until lightly browned. Add other ingredients, season with salt and pepper, simmer until tender, about thirty minutes, and serve on the toast.

Artichokes with Cheese

6 small boiled or steamed globe artichokes	$\frac{1}{4}$ cup melted butter (extra)
3 teaspoonfuls butter	$\frac{1}{2}$ cup grated Parmesan or American cheese

Oil a baking dish with butter; put in the artichokes with a half teaspoonful of butter in the middle of each. Sprinkle with the cheese. Cover, bake fifteen minutes, and pour the melted butter over just before serving.

Stuffed Artichokes

Allow a small globe artichoke for each person. Boil or steam, remove the hearts and stuff with equal parts of minced chicken and ham, with cream or bechamel sauce to hold together.

In selecting broccoli, care must be taken not to get the so-called "Italian broccoli" which is sold in some markets. It is a leafy vegetable which when cooked has a bitter taste that is disagreeable to many persons. The true

broccoli (which is also associated with Italy and other southern European countries) is a close relative of cauliflower and is much more delicate in taste.

To prepare broccoli, wash, soak in cold salted water thirty minutes to remove any insects, cut in coarse dice or trim in even lengths, and tie in cheesecloth. If it is to be steamed, first sprinkle it with salt. If it is to be boiled, add one teaspoonful of salt to a quart of water. Cook twenty to thirty minutes and season with one tablespoonful of butter to three cups of prepared vegetable, and add salt and pepper to taste. Serve on toast like asparagus, with savoury egg or cream sauce, drawn butter, hollandaise or mousseline sauce, or green pepper sauce.

Eggplant lends itself to many different ways of preparation. It is most frequently served fried, but that gives little idea of its possibilities.

Baked Eggplant

Wash a medium-sized eggplant, place in a pan containing a very little hot water and bake until tender, about an hour. Test with a fork. Peel and serve mashed, seasoned with one tablespoonful of butter to each pint of pulp, salt, pepper and a trace of sugar to taste, or in pieces with melted butter, lemon juice and a little parsley poured over.

Mashed Eggplant, Southern Style

Boil or bake the eggplant, mash with a potato masher, and to each pint of pulp add one tablespoonful of butter, a few grains of sugar, salt, pepper and onion juice to taste.

Eggplant au Gratin

In a buttered baking dish put alternating layers of mashed eggplant, buttered soft bread crumbs, and grated cheese. Brown in a hot oven, 375 degrees F., and serve with chili sauce.

Eggplant Puff

1 pint mashed cooked eggplant	1 tablespoon flour
3 tablespoonfuls butter	1 teaspoon salt
3 eggs	Few grains pepper
$\frac{1}{2}$ cup milk	1 teaspoon sugar

Combine the eggplant, seasonings, flour, the butter melted, milk and egg yolks beaten, fold in the whites whipped stiff, turn into a pudding dish and sprinkle with grated cheese and bread crumbs; set in a pan of hot water and bake until firm in a moderate oven, 350 degrees F., about thirty-five minutes. Serve plain or with white sauce.

Fricassee Eggplant and Mutton

1 good-sized eggplant cut in inch cubes
$2\frac{1}{2}$ cups cold mutton cut in inch cubes
2 tablespoonfuls butter
1 tablespoonful flour
1 pint soup stock, any kind
Salt and pepper to taste

Melt the butter and brown the mutton in it. Season with salt and pepper. Remove the meat and fry the eggplant. Add to the mutton, stir in the flour, and when it is browned, the soup stock. Season to taste with salt and pepper and serve with boiled rice or mashed potato.

Another of the vegetables less commonly found on our tables is salsify. To prepare for cooking, remove the tops, scrape the roots, and drop into water containing one teaspoonful of vinegar to the pint, to prevent discoloration. Rinse in fresh water and cook as desired.

Steamed Salsify

Prepare as directed, dust with salt, and steam until tender, about thirty-five minutes. Dice or cut in inch lengths and season with one tablespoonful butter to three

Does Your Laundry Wear Out Linens— before their time?



No matter how modern your equipment for other laundry operations, you can't help shortening the life of linens unless you "Dry-By-Air" in the Vorclone. For Vorclone dries successfully at 125° — no other tumbler can. Eliminates high temperature. Avoids destroying the natural oils that give life to textile fibre, adds months to the life of linens.

Vorclone does not depend on heat to dry. The patented Vorclone fan draws tremendous volumes of fresh, mildly warm air thru the tumbling clothes, duplicates the old-time standards of outdoor drying. No scorching. No discoloration. No shrinkage. No unpleasant odors. No lint accumulation on the clothes or the machine.

Vorclone Dry-By-Air is a vital factor in linen costs. Many pieces last as much as 50% longer. And with "clothes-line quality" comes a big saving in drying costs. The average cost of drying with the Vorclone is less than a quarter of a cent per pound.

Mail the coupon for complete facts on Vorclone-equipped hospital laundries.

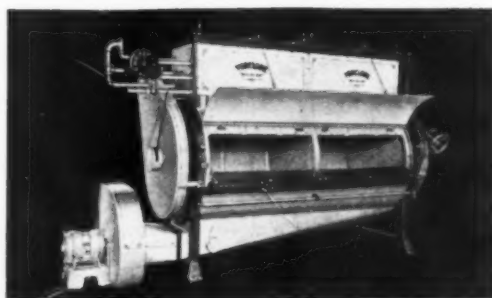
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Number of Beds.....

M. H.

cups of the vegetable. Add salt and pepper and a little sugar as needed.

Escaloped Salsify

Put creamed salsify (three cups of diced salsify to one and three-quarters cups of cream sauce) in a buttered baking dish, cover with one-half cup fine dry bread crumbs, mixed with a tablespoon of melted butter, and brown in a hot oven, 375 degrees F.

Salsify en Casserole

Butter a casserole and put in three cups sliced raw salsify, prepared as directed and mixed with two tablespoonfuls of flour. Cover with boiling soup stock, put on the cover, and bake until the salsify is tender—about an hour.

Okra, to most of us, means the green pieces that are swimming in some soups, but it has its own place as a vegetable accompaniment of the main course of luncheon or dinner. It is especially good with fish or salt fish. Wash the okra and slice across or lengthwise, then cook as desired. Some people object to the mucilaginous quality of okra and this can be overcome by adding a tablespoonful of vinegar to each pint of the cooking water.

Steamed Okra

Prepare as directed, place in steamer with one cup of boiling water, add one-half teaspoonful of salt, and steam until tender, about forty-five minutes. Serve plain with a seasoning of one tablespoonful of butter and one teaspoonful of lemon juice to a pint of okra.

Baked Creamed Okra

3 cups cooked okra ½ cup dry bread crumbs
1¼ cups white sauce 1 tablespoonful butter, melted

Combine the okra and sauce, transfer to a baking dish, cover with the crumbs and butter mixed, and brown in an oven, 350 degrees F.

Okra Cooked with Corn and Tomato

1 pint sliced okra 1 pint grated fresh or
1 pint canned or stewed canned corn
tomato 1 onion, minced
1 tablespoonful butter 1 teaspoonful salt
½ teaspoonful sugar ¼ teaspoonful pepper

Combine the vegetables and seasonings, transfer to a double boiler, cover, and cook until tender, about forty-five minutes. Serve plain as a vegetable, or as a sauce to boiled, buttered spaghetti, or brown rice (with or without grated cheese) or serve with potato croquettes.

Mushrooms, part of the year at least, are coming out of the luxury class and everyone should enjoy this delectable food. The following recipes will suggest a few of the more unusual ways of serving them.

Mushroom Croquettes

2 cups finely chopped peeled ½ cup very thick brown
mushrooms sauce
1½ cups cooked brown rice ½ teaspoonful salt
2 egg yolks ½ teaspoonful onion juice

Combine the ingredients in the order given, shape as desired, and fry in deep fat hot enough to brown a piece of bread in a minute, 350 degrees F. Serve with mushrooms in brown sauce or sauce bechamel.

Mushroom and Potato Pie

4 cups mashed potato 2 tablespoonfuls butter
1 egg, beaten 1½ cups brown sauce
3 cups coarsely diced mush- ½ cup grated cheese
rooms

Sauté the mushrooms in the butter five minutes and add the sauce. Heat. Line a buttered baking dish with the mashed potato and egg beaten together. Fill the center

with the mushrooms, cover with more potato, sprinkle with the cheese, and bake thirty minutes in a hot oven, 375 degrees F.

Mushroom and Chicken Jelly Salad

1 cup diced cooked chicken
1 cup diced steamed mushrooms
½ cup diced celery
1 tablespoonful granulated gelatine
2 tablespoonfuls minced green pepper
1½ cups chicken stock
Few drops onion juice
Salad greens

Soak gelatine for five minutes in cold water to cover, add to the stock, which should be boiling, a little onion juice and the remaining ingredients. When beginning to congeal, stir, transfer to a mould, and when firm unmould and serve with a garnish of cress, lettuce, or celery curls and mayonnaise.*

GETTING FULLER COOPERATION IN THE CARE OF THE MENTALLY ILL

A step to stimulate psychiatric work and further the better treatment of cases of mental disorder in England was taken recently by the Royal Medico-Psychological Association, which sent circulars to every mental institution in England inviting the medical superintendents of the institutions to afford to their staffs facilities for attending clinical meetings, in accordance with a plan the organization of which is now under consideration, according to the *Lancet*.

It is proposed that these meetings should be held under the auspices of the association, and to encourage the attendance of the workers in psychiatric establishments the managing bodies will be asked to sanction traveling and other reasonable expenses to their medical officers. The movement is in accordance with the expressed wishes of the boards of control in England and Wales, and in Scotland. The circular suggests that the clinical meetings should not be limited to members of the association, but that all medical men, institutional officers or private practitioners should be made welcome.

A memorandum on the subject, issued by the association, expresses the hope that there may be twelve meetings a year in each of certain areas whose size remains for decision, and that a special point at these meetings should be made of the study of groups of cases presenting similar symptoms.

"All will agree with the implication that the demonstration of actual cases at clinical meetings is more instructive than the reading of papers," says the *Lancet*, "and the scheme does not depend for success upon securing large attendances; small gatherings at which interchanges of personal experience can take place should give better results than crowded meetings."

"The existing plan of the association will need to be divided into areas in accordance with the number and situation of the mental hospitals, but the actual scheme has not yet been formulated, and for pecuniary reasons the support of the local authorities will be required, for it is unreasonable to expect the medical staffs of the institutions to finance a great educational design as well as provide for its scientific and practical working. The most valuable result of such a scheme would be the relief from isolation of many medical institutions."

*Menus from "Menus for Every Occasion," by Tipton; recipes chiefly from "Vital Vegetables," by Allen.



Receiving Hospital and Nurses Home, City of Detroit — one of the new hospitals recently to be equipped with Clow Plumbing. Architects and Engineers: Corey & Esselstyn.

For the most important 10%



WHEN the average hospital is built, only ten per cent of the total cost is spent for plumbing — *the most important part of all.*

The life of the average hospital building is probably sixty years. The life of *average* plumbing is usually only ten years. Replacements and repairs drive average plumbing costs up—from the original ten per cent, to six times ten per cent!

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OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United

Hospital Fund of New York, 151 Fifth Avenue, New York

A. K. HAYWOOD, M.D., Superintendent, Montreal General Hospital, Montreal, Que.

HARPER HOSPITAL OUT-PATIENT DEPARTMENT EXTENDS ITS CLINIC SERVICE

By Alice H. Walker, Director, Social Service Department, Harper Hospital,
Detroit

THROUGH an increase in the total number of patients served, expansion and better organization of clinics, and a distinct gain in the quality of service, the out-patient department of Harper Hospital, Detroit, is striving to meet the needs of Detroit's growing population. The following table gives a bird's eye view of the progress made in the past three years:

	1924	1925	1926
Patients in Out-Patient Department	9,262	10,046	10,804
Visits to Clinics.....	54,536	61,015	71,394
Social Service Cases...	1,907	2,236	3,152
Visits to Patients'			
Homes	3,048	3,469	4,380
Visits to Social Agencies	2,621	3,599	3,661
Budget for O.P.D. and S.S.	\$63,758.48	\$74,992.72	\$92,786.16
Clinic Collections	\$18,495.13	\$26,771.82	\$34,307.49

In February, 1923, the scope of the service was greatly broadened through reclassification of patients and a re-adjustment of clinic fees, permitting a careful adaptation of service to the particular groups in the community who need what the out-patient department has to offer. We are now able to treat patients who were hitherto deemed ineligible. Detroit, the Mecca for job seekers, has so long been regarded as the seat of the proverbial pot of gold at the end of the rainbow that the necessity for this extension of clinic service might be questioned. Our studies of incomes and family budgets, however, have established the justice of our policy.

What Does Average Income Purchase?

From the income tax figures and other sources it has been determined that the incomes of the large majority of the population of the United States are under \$3,000 per year and the incomes of the majority of individuals of Wayne County under \$2,400. Indeed, the earnings of the average automobile factory worker in Detroit in 1925 and 1926 ranged from \$1,500 to \$2,400, averaging around \$1,800 a year. The purchasing power of this average income is gauged by checking it against the minimum budget as estimated by the Visiting Housekeeper Association, Detroit.

Minimum Budget for Wage Earner's Family (Man, Woman, Girl 5, Girl 12, Boy 14)

	October 1, 1926	
	Month	Year
Food	\$ 51.89	\$ 622.68
Clothing	25.31	303.72
Rent	37.00	444.00
Furnishings	9.04	108.48
Fuel and Light	12.57	150.84
Extras	7.58	90.96
Insurance	2.44	29.28
Health	6.84	82.08
Savings	10.00	120.00
Total	\$162.67	\$1,552.04

3.83 per cent decrease in food since July, 1926.

2.91 per cent decrease on entire budget since July, 1926.

The cost of living is rated higher for Detroit by the National Industrial Conference Board than for any other city in the Union, with the exception of Seattle, Wash. This minimum budget allows only \$82.08 yearly for health which is obviously much too low for the family in which much sickness occurs. At the same time this minimum budget of \$1,952.04, necessary for decent living, is over \$100 higher than the total yearly wage of the average factory worker. Thus it devolves upon the out-patient departments of hospitals to supply nominal pay clinics for the use of small wage earners as well as free service for indigents.

Two of the outstanding needs of the out-patient department are the appointment of a full-time medical director and a revised record system. New record forms are now under consideration for the clinics, which will become part of the unit record system in the new hospital.

How Follow-up Increases Clinic Visits

The average number of clinic visits is 6.60 per patient. This high average is due in part to the frequent visits over an extended period of time paid the physiotherapy and venereal clinics. A close follow-up is maintained for all clinics, 8041 visits having been made by the hospital workers in the interests of the patients for medical follow-up and for social treatment. The cosmopolitan population of Detroit is well represented in the forty-five na-

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tionalities found among the new patients. Nine per cent of the total number of new patients were negroes. Sixty-seven per cent were housewives and minors.

The medical clinic, the pivotal clinic of the out-patient department, has been greatly strengthened through subdivision into special clinics and by the adoption of the appointment system. The organization of classes for instructing cardiacs, tuberculosis and diabetic patients saves time and promotes effective teaching. The group work is supplemented by individual instruction in the homes. In these clinics the social case worker works along with the doctor, the nurse and the dietitian in well organized team play. The working capacity of each patient is estimated carefully by the physician and some constructive social work has been done by the case workers in fitting these handicapped patients back into the community. The hospital wards are closely correlated with the out-patient clinics, thus insuring continuity of service.

Physiotherapy Department Is Self-Supporting

The expansion of the physiotherapy department has exceeded our expectations. Four full-time physiotherapists are kept busy continually. Despite the fact that over one half of the patients treated are unable to pay for care, this division is more than self-supporting. Three full-time dentists are employed in the dental clinic. With a little effort and careful study both physiotherapy and dental clinics could be enlarged to care for a much larger group, particularly in the industrial field. The reorganization of the dermatological and the genito-urinary clinics, the forming of the important division of cystoscopy, the greater regularity of attendance of staff members and the weekly conferences held in the several clinics throughout, all point to a healthy growth in the out-patient department.

There have been 181 cases handled in the cancer clinic since its reorganization in July. A careful follow-up insures an exact schedule of x-ray therapy and other treatments and it is possible at an early date to plan for the malignancies, who, socially as well as medically, will need intensive care at the end.

The disposition of this malignancy group is exceedingly difficult because of the lack of hospital space for chronic cancer cases. At present, the Wayne County Infirmary is almost our only resource and this does not offer a good solution for many of the patients. Indeed, the matter of providing sufficient hospital beds for patients who are acutely ill, to say nothing of chronic cases, is one of Detroit's gravest problems.

Too Few Convalescents' Beds Available

Second in importance is the wholly inadequate provision for suitable convalescence for the patients from sub-standard homes. If Detroit had accommodation for convalescent patients comparable to New York or Philadelphia, the hospital capacity in this city for acutely sick patients could easily be doubled, to the mutual advantage of the acutely sick and the half-cured patients. Due largely to the efforts of the social service department of Harper Hospital, a small beginning has been made in the matter of providing convalescence. There is now available a partially endowed twenty-six-bed convalescent home.

The neuropsychiatric clinic, established two years ago, under the able leadership of Dr. A. L. Jacoby, continues to make a noteworthy contribution not only to Harper Hospital but to the community in general. The report of Maud Watson, case work supervisor, shows the main activities of this clinic to have been three-fold:

First, the diagnosis and treatment of patients. There have been as new patients under care:

Children under 13 years of age.....	147
Adolescents under 20 years of age.....	160
Adults	268

These patients have all had complete histories compiled by the social workers, and 463 have had psychometric examinations (evaluation of intelligence) before the first appointment with the psychiatrist, or in some cases, the neurologist. Whenever the psychiatrist has recommended that the patient be referred for social service, the patient has been assigned to a social worker for social treatment. Three thousand and ninety-six visits were made by the social workers in social investigation and treatment.

Second, the clinic has served as a steering agency for 169 patients, ineligible for clinic care, who have come for advice as to where they might have their children, who are behavior problems, examined, or to whom they might go for assistance in working out their own personal problems.

Third, personality studies have been made on ninety-four probationers of the Farrand Training School for Nurses. The clinic has acted in an advisory capacity in helping to straighten out the unadjusted student nurse or the student with the most apparent personality difficulties.

These personality studies made at the request of the Farrand Training School, and the interpretative talks on "personality" are undoubtedly among the most constructive of all the varied services of the neuropsychiatric clinic, and it is manifest that in time a valuable contribution will be made to the nurses' training schools of the country. When this work is further supplemented by lectures on the fundamental principles of psychology and sociology, the growing understanding of the interrelation between the physical and the mental equipment will be advanced, and the students will become more quickly in tune with their environment and profession.

Evening Clinics Three Times Weekly

The excellence of the work of the neuropsychiatric clinic has been recognized by the Smith College School of Social Work which has asked the privilege of assigning two students for the period of one year for field work and study.

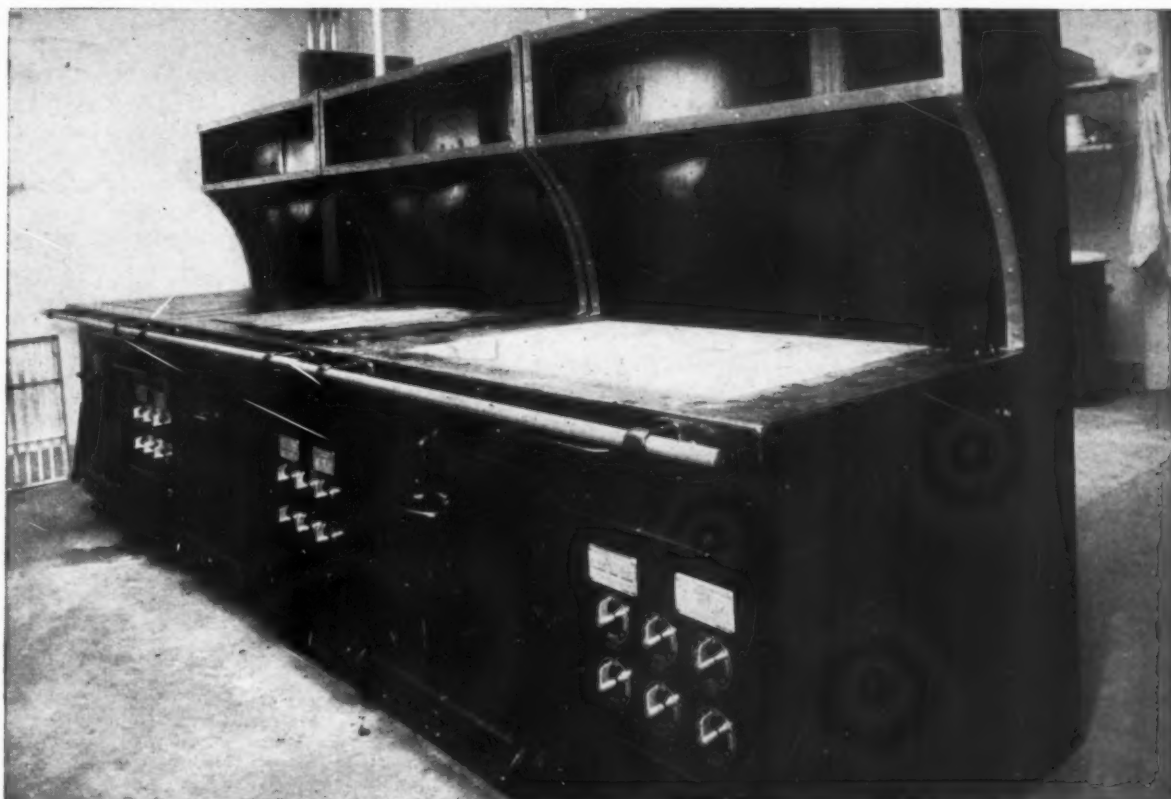
The evening clinics opened in June are held three times weekly from 6 to 8:30 p. m. Almost invariably the patients who present themselves have some serious ailment. These clinics are singularly free from "clinic shoppers." If not too ill to be treated as ambulatory patients, they are able to carry on their work which is a matter of supreme importance to the head of a household, the clerk, the stenographer or others on small wages. The physicians are paid for their services. These clinics have been self-supporting from the second month of their existence.

We continue to give instruction in the social service department to student nurses, student dietitians and to a limited number of volunteers. Two students from the University of Michigan, Ann Arbor, Mich., spent the semester from February to June in part-time field work. One student returned after commencement for six weeks' intensive training.

Staff meetings and case work conferences are held weekly. New schedules have been worked out for student nurses and student dietitians. We are working toward a revision of our social recording system and a clear-cut analysis of our function as case workers in a hospital, believing that we must have our object and methods

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clearly defined if our work is to be entirely effective.

There has been a noticeably closer tying up with many of the other social agencies of the community, as evidenced by the team work with the Tuberculosis Society of Detroit and Wayne County in the care of cardiacs, the neuropsychiatric work with the Girls' Protective League and special work with problem children, as carried on with the Methodist Children's Home Society. This dovetailing with other social agencies has been further promoted by means of case conferences. From time to time representatives from social agencies mutually concerned with us in the social maladjustment of certain families have been invited to meet at this hospital for serious study of cases whose complex social and health problems require earnest, correlated community effort to effect a solution. These conferences effected less duplication of effort, fewer purposeless motions and better understanding of the functions of the respective agencies, and they have usually resulted in a satisfactory plan for the family.

Our work has been hampered to a certain extent this year by several changes on the social service staff but it may be said without reservation that we now have a stronger personnel, made up of better trained workers, than ever before in the history of the department. Of the seven new workers, all university graduates, who have been added to the social service staff this year, six have had graduate training in social service at well recognized schools of social work. One new worker, a graduate of the Chicago University School of Education, Chicago, has been added to the staff of clinic executives.

Well Trained Workers Needed

We believe that the future of social work, not only in Harper Hospital but in the community, depends upon building up a strong corps of well trained workers, but until cognizance is taken of the years spent in preparation for scientific social work, and salaries commensurate with the expenditure of time and money are paid, it will be difficult to attract and hold the type of workers desired. Under the present system of ungraded salaries which prevails in Detroit, the carefully trained social worker must compete with untrained or poorly trained workers. So long, too, as municipal agencies offer salaries far in excess of what the private agencies can afford to pay, it will be a difficult task to build up and maintain a competent staff.

The concern of the social workers has been not only with the patients with whom we come in daily contact. We have been actively interested in the state and national associations of hospital social service and in the social organizations and clubs of the community. Speakers have been supplied for clubs, churches and schools. Our best effort has been devoted to the promotion of scientific social work and our objective for the coming year is to prove the social service department an indispensable adjunct to the medical work of the hospital, making a contribution of real value in the scientific study and treatment of patients and in medical research.

WARD ADMINISTRATION SHOULD BE CAREFULLY PLANNED

Many important points touching upon the subject of ward administration are interestingly discussed by E. M. McKee, superintendent, Brantford General Hospital, Brantford, Ontario, in an article in the *Hospital, Medical and Nursing World*. Miss McKee views the subject from three standpoints: the care of the patient, the edu-

cation of the nurse and the responsibility of the administrator to the board of governors for efficient management of the entire institution. She says in part:

"A ward should be looked upon as a hospital within a hospital. The details of proper structure and layout of wards are important, but are a separate subject. Those people actually working on hospital wards or special departments, however, should have in mind a carefully thought out, uniform and definite plan of ward structure which they could present to hospital administrators when wards or departments are being built or remodeled in any way.

"A ward, to be well operated, must be self-contained, having complete equipment for fulfilling the needs of the particular branch of work for which it is established, whether surgical, medical or obstetrical. It is wasteful of time, energy and material to have floating equipment. What belongs to everybody belongs to nobody. If this condition exists it is impossible to determine the efficiency or inefficiency with which separate wards are being operated. It is certainly no stimulus to ward administrators.

Provide Sufficient Equipment

"The ward equipment should correspond in character to that provided and considered essential in classroom teaching, and should be sufficient to insure maximum service in a minimum amount of time. Truly, it is desirous to teach the student how to improvise should the occasion for so doing arise, but for daily practice the student should be taught to use the right article for the right purpose. The initial outlay to provide sufficient equipment to insure that there will be no shortage is great, but the returns in saving are correspondingly great. It is the duty of the hospital administrator to provide this equipment. We have all seen a bandage or a towel used on a banging door when a proper silencer should have been supplied, or a burnt towel as a result of proper night light being unavailable.

"The ward, having been equipped, should be carefully and systematically inventoried. It would seem that a good plan would be to list articles in the places in which they are to be kept permanently, and that as far as possible there should be uniformity throughout the various wards of the hospital, so that the students being transferred from one ward to another may have some conception of the ward plan and will know where to look for the articles required. The inventory, once completed, should be verified at least monthly. At this time all articles, if misplaced, should be returned to their proper places and all articles lost during the month and not recovered should be replaced. It is not economy to allow a ward to depreciate. It is surprising, however, the number of missing articles that can be recovered under careful supervision and with good cooperation from all concerned.

"Having equipped and inventoried the wards, there should be a systematic method adopted for the requisitioning of supplies. Under efficient management sufficient supplies should be ordered at one time for a week's requirements, taking, perhaps, different groups of supplies different days of the week. There are, of course, daily requirements, such as food, drugs and laundry. A day should be left free for the storekeeper to put his department in order and to check up supplies, making sure that he has the minimum stock on hand. In installing any system of requisitioning there are three considerations: the ward needs, the organization of the stores department and the detail for the business office."



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SKINNER, SHERMAN & ESSELEN, INC., Consulting Chemists, "The Food Value of the Banana."

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Water	Carbohydrate	Protein	Fat	Mineral Matter	Calories per Pound
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The largest solid content of the banana (carbohydrate) is the food element of which the body requires the largest proportion.

COMBINED with milk, bananas provide an ideally balanced food, a fact evident in the following analyses as given in Locke's "Food Values":

Calorie Values

	Carbohydrates	Fats	Proteins	Total Calories
Banana (average size)	113.7	7.3	6.4	127
Milk (1 glass) . . .	45.1	81.8	29.8	157
Total	158.8	89.1	36.2	284

THIS high food value and balanced quality have made Ripe Bananas and Milk a standard diet for children, the under-nourished and the convalescent and all for whom a highly nutritious, easily digestible diet is essential.

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Grasslands Hospital, Valhalla, N. Y.

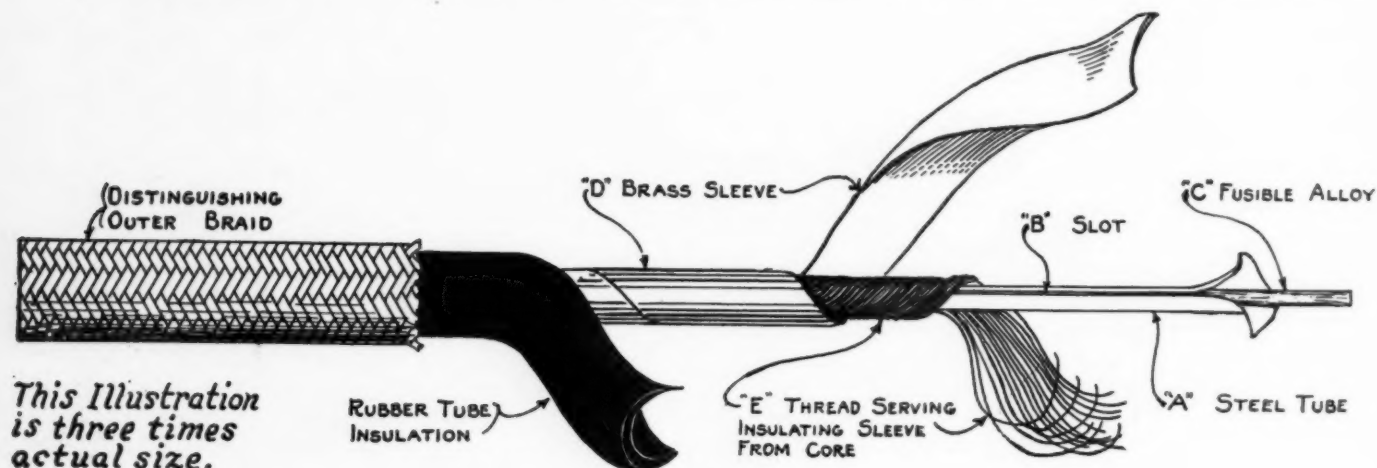
A FIRE DETECTING SYSTEM THAT ELIMINATES THE HUMAN ELEMENT

A FIRE detecting system that gives promise of practically eliminating the human element ordinarily necessary to the discovery of fires, has recently been put upon the market. This system is ingenious and has been worked out with careful attention to the smallest details.

The feature of the system is its ability to report excessive heat in any part of a building where it has been installed. Threatened fires from spontaneous combustion and certain other causes are seldom detected before they reach the smoke and flame stage. A fire can by this

means be detected before it would be apparent to the eye or to the sense of smell. In a building thus equipped it is almost impossible for a fire to gain any sort of headway before an alarm is automatically sounded.

A fire detecting wire is placed in all rooms, attics, stairwells, workshops and corridors. It is possible to use the system only for certain places where the fire hazard is especially great, or it may be installed so as to cover every part of a building. This fire detecting wire is best explained by the accompanying diagram. The principle is that of fusion by heat of a metal alloy that causes a



FIRE DETECTING WIRE

This wire is a waterproof continuous automatic thermostat. It has two conductors.

The inner conductor, called the core, "A" is a laterally slotted "B" steel cylinder, which is filled with a fusible alloy "C."

The outer conductor is a spirally wrapped brass tape "D."

These two conductors are separated by means of a thread serving "E."

When the temperature of the wire is raised the alloy "C" fuses, expands and spurts through the lateral slot "B" permeating the threads "E" and contacts with the brass sleeve "D." This makes a "short" and the fire signal is given.



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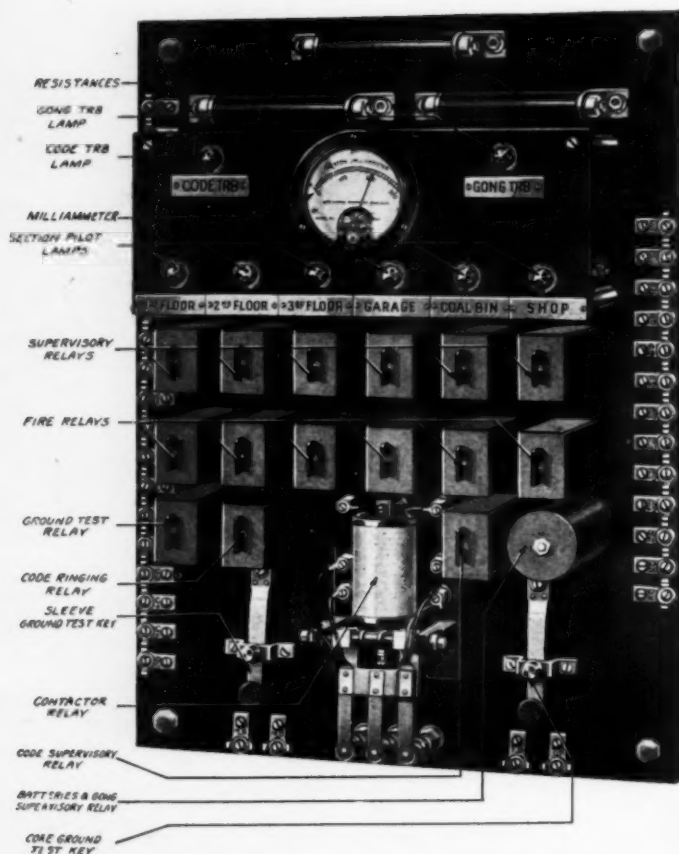
No wonder, too, that such care in manufacturing adds to the recognized Pequot durability a long list of other desirable qualities: Permanent whiteness, uniformity, easy washability, and that luxurious Pequot "feel".

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BHD



short circuit in the wire and immediately sounds the fire alarm.

The special fire detecting wire is placed at or near the top of rooms or places desired to be protected. All connections between these special units and the system of fire gongs are of wire of ordinary type. The detecting wire may be tinted to blend with colors of walls or mouldings. It automatically registers an alarm whenever the heat reaches 160° F. After a small portion of the wire has been fused in reporting a fire, that part may be readily replaced at small cost, and a warning buzzer will continue to ring at the central control station until this replacement has been made. The entire system operates on a closed circuit principle. If anything happens to any part of the system that would put it even slightly out of order, this trouble is immediately recorded at the central station and the signal, which cannot be turned off, continues until the trouble is located and repaired. This fire detecting system appears to be ready to do its job whenever the crucial moment arrives.

There is also a complete arrangement of emergency lights operated from the batteries controlling the system. Whenever a fire alarm is sounded, these emergency lights in stairways and other strategic locations are automatically turned on, and in case a fire puts the regular electrical system out of order, they prove valuable.

Alarms are recorded in much the same manner as in the ordinary system by means of code taps on the fire alarm bells. An arrangement is possible whereby a fire in a single room will be reported only on the floor in which it occurs, but in case the fire spreads to the corridor, the general alarm will be sounded.

The system also provides for the draining of tanks containing paint or other inflammable liquids to some safe outside location as soon as an alarm is sounded. Exhaustion of the battery charge is guarded against

inasmuch as there is an auxiliary battery that can take the load for a considerable time, and as soon as the charge of the main battery reaches a certain low point, a buzzer alarm is sounded at the main station.

Fire alarms may be turned in by means of a key to be used in fire alarm boxes which may be placed at any desired points. This arrangement is also useful in conducting fire drills whenever desired.

As has been stated, the two principal features distinguishing this system from those that have been more familiar in the past are (1) its ability to detect and report fires without considering the human element at all, and (2) the use of the special detector wire shown in the diagram.

A demonstration of this device should be seen to be thoroughly appreciated; to the uninitiated it would seem impossible to obtain so complete a safeguard against fire by mechanical means.

ECONOMICAL PORTABLE ALCOHOL DISPENSER

This new apparatus will undoubtedly meet a real need in the hospital field. It is designed to give the maximum amount of service at a minimum cost for alcohol or cresol. By stepping on the foot pedal, alcohol or cresol is quickly



sprayed over the surgeon's arms and hands in sufficient quantity to disinfect them thoroughly. The small amount that runs off will drain back into the empty bottle, so that it may be filtered and used again. In the event of breakage, any part of the dispenser may be replaced easily.



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And, used unsparingly,
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As delicious a dish as you can set on a tray

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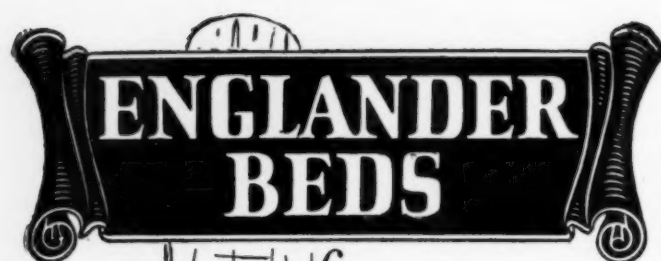
Orange
Raspberry
Coffee



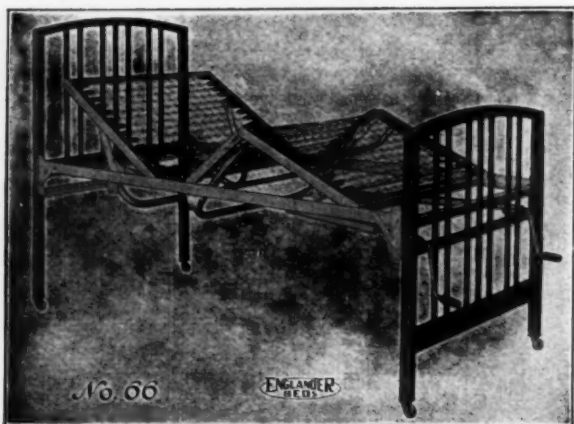
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Hospital for Joint Diseases, New York City	St. Luke's Intern'l Hospital, Tokio, Japan
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**AN ADHESIVE PLASTER DISPENSER THAT
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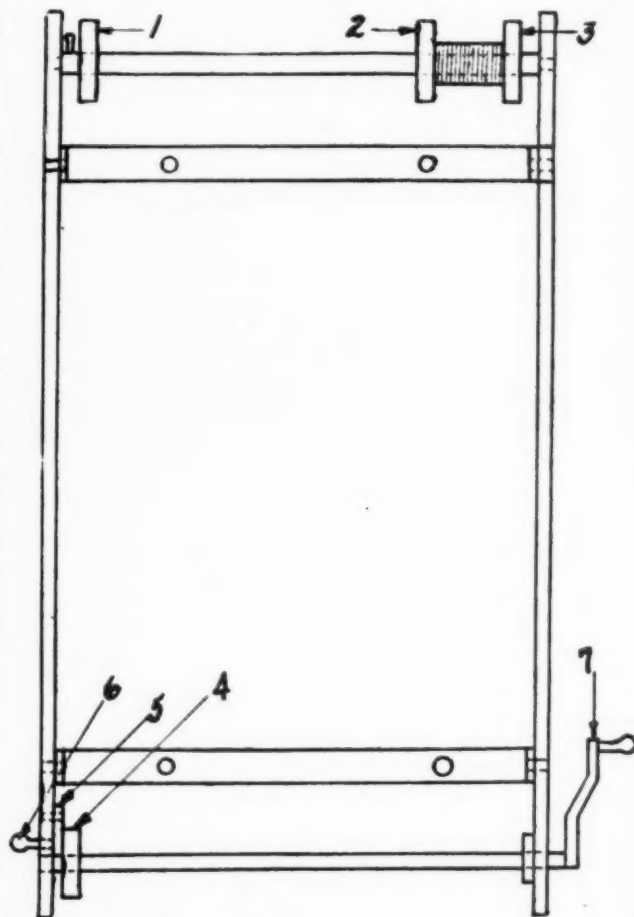
By M. Raymond, M.D.
Homer City, Pa.

The rack here illustrated is designed to hold a roll of adhesive plaster in such a manner that the adhesive can be conveniently removed from the gauze as needed and the gauze wound on another roll.

It consists essentially of a rack fastened to the wall and serving as a support for the two rollers—the upper one for the roll of plaster and the lower for the gauze.

The vertical members of the rack give stability to the apparatus.

A device to hold the roll of plaster on the upper roll or rod from turning too easily consists of a loose collar



1. Removable collar, held by thumbscrew; 2. Loose collar; 3. Tight collar (coil spring is between); 4. Tight collar; 5. Friction brake consisting of leather facing on steel; 6. Thumbscrew; 7. Handle for winding up the gauze.

that is held firmly against the end of the roll of plaster by a spiral spring which slips over the rod.

The lower rod, upon which the gauze is wound, holds the gauze and plaster taut while the latter is removed by tearing upward. A small friction brake is adjusted by means of a thumb or set screw against a smooth, tight collar on the rod, effectively preventing the rod from turning backward.

The rack is manipulated as follows: The collar (1) is removed by loosening the thumbscrew and the rod pushed through the center of the roll of plaster. Then the collar is replaced and pushed with the roll against the other end to compress the spiral spring until the end of the rod at (1) is exposed, when the thumbscrew is tightened. The whole is then replaced in the rack,

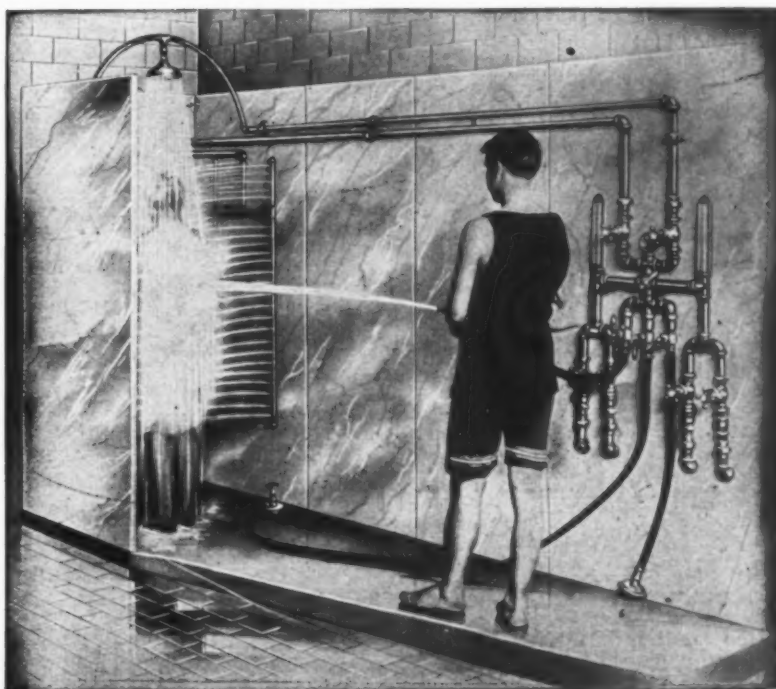
EFFICIENCY *and* ECONOMY

WITH BATTLE CREEK HYDROTHERAPY EQUIPMENT

"There is no remedial agent so flexible or so perfectly adapted to the treatment of disease as is water"

No hospital superintendent or physician is a stranger to the vast good embodied in Hydrotherapy. It ranks with "Light" as a pioneer in Medicine. It is one of the original 'specifics' and has stood the test of time.

The Battle Creek Hydrotherapy Apparatus still retains the position it created years ago. It is the oldest, simplest, most efficient, and most accessible type available. With this apparatus there are no expensive installations, no unhandy and inaccessible valves, and no buried piping necessitating the tearing up of a wall or floor to repair.



The G-3 Hydrotherapy Apparatus is complete, fitted to give the overhead and needle showers, rain, perineal, jet, revulsive, Scotch, and any other form of douche. All metal parts are made of heavy brass Nickel-plated. The pipes are made of the finest brass and are the one inch iron pipe size. The temperature regulating valves and the needle and overhead shower control valves are the standard compression type. The quick-change valve, located in the center of the control section, is made of babbitt metal and will wear indefinitely. The hose used with the nozzle, perineal and rain douche is the best rubber procurable.

OTHER RECOGNIZED BATTLE CREEK APPLIANCES

Electric Light Bath Cabinets

Three models, varying in size and cost. Each cabinet complete with special comfort chair and necessary bulbs. Made of the finest hard wood water-proof cemented veneer. All models shipped ready to install.

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An ingenious apparatus which gives massage better than the hand and with which every part of the body may be treated. Built to stand the strain or hard, daily institutional service. No attendant needed.

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A thoroughly practical means of applying vibration to all parts of the body. Highly beneficial in chronic cases where physical exercise is denied. A popular health aid for institutions and physician's offices.

The Radiantor

A portable electric light bath in compact form. May be applied while patient is in reclining or sitting position. Especially adapted to the needs of ward hospitals and small institutions where conservation of space is a factor.

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A powerful vibrator that is built to stand hard service. Enables the operator to apply deep vibrations to any part of the body in three different forms—percussive, lateral or centrifugal.

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Heat is circulated by electric water heaters, under the table as well as the shelves in the closet. Large meat platter, 10x12 inches, is covered with telescope cover.

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Ask us about this table. We carry a complete line of hospital kitchen equipment that has been made superior through more than fifty years of experience in this field.

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Hurley Machine Company
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Thor

**HOSPITAL
Laundry Equipment**

and the end of the gauze pulled down and started on the lower rod by turning the handle. The plaster is removed by tearing off the strips from below upward. When the full width is uncovered, the gauze is wound up until the edge of the plaster is brought down to the lower roll.

Some of the advantages of this rack are: There is only one handling of the plaster; the plaster is kept clean and sterile; both hands are free to handle plaster strips; loose ends left over are stuck back on bare gauze instead of on the wall, thus making more tidy dressing station; plaster is saved and every bit is used. When pieces are stuck to the surface of the wall, they often lose their adhesive quality and have to be discarded, thus causing waste.

A BASSINET STAND FOR ISOLATING INFANTS

The Woman's Hospital in the State of New York, New York, has recently designed a bassinet stand and unit for the segregation and isolation of newborn infants. These bassinet stands are placed in small cubicles, as shown in the illustration, and permit the complete isolation of the patient. The hospital is finding this new piece of equipment very helpful.

The principal feature of the stand is the monel metal sliding tray upon which the infant may be placed for



bathing, dressing, and treatments. This tray obviates the necessity of carrying the infant to the central bathing table of the nursery. It is easy, by means of the locker, to keep all equipment separate and in good order.

It appears feasible and desirable for entire nurseries to be equipped with bassinets of this kind, because of the possibility of lessening the danger of cross infection. Also, hospitals following the usual plan of having a central bathing and pinning table might find it desirable to use one or more of these units for infants whose condition for any reason requires isolation.



Your nose is a LIAR!

Yes it is! Bad odors and contaminating smells, the nose either misinterprets or misses. That's why we ignore the foul odors, the acrid smells of decay and heavy fumes from clogged drain pipes all of which defile the air and help the growth of bacteria.

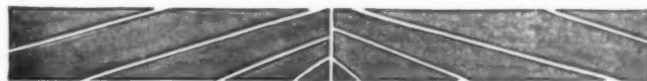
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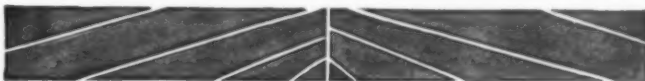
Vita Glass is valuable

ONE of the first questions asked by incoming patrons to the Haven Hotel, Sandbanks, Bournemouth, England, is: "Where is the vita glass sun lounge?" Manager Ruttle, of the hotel, states that "if the air is in any way cold outside, those particularly who are recuperating from illness like to rest in this lounge as they feel that by doing so they are getting as much benefit as if they were exposed to outdoor sunshine!"

Vita glass transmits ultra violet irradiation to the extreme limit of the sun's spectrum, including the vital rays. It may be had in two forms—clear and translucent (cathedral). In appearance both are virtually indistinguishable from ordinary glass. The transmission qualities of both are attested by unimpeachable authorities.

The value of Vita glass has been proved during two years of actual use in schools, hospitals, and homes. It is being installed everywhere, for people everywhere are learning the value of the ultra violet irradiation which ordinary window and plate glass obstructs.

Let us tell you about Vita glass in detail. VITAGLASS CORPORATION, 50 East 42nd Street, New York, N. Y.



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HUNDREDS of hospitals by their experience have proved that men trained in financial campaigns raise more money more easily than untrained men.

Over \$208,500,000 has been raised for religious and philanthropic institutions by members of this organization.

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Campaigns undertaken anywhere. We care for every detail.

We have raised money in recent years for dozens of hospitals from Pawtucket to San Francisco.

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The die operating in the National Marking Machine forces your indelible ink mark into the very fibre of the linen or cloth to be marked. We cheerfully submit original sketch of die design for your approval.

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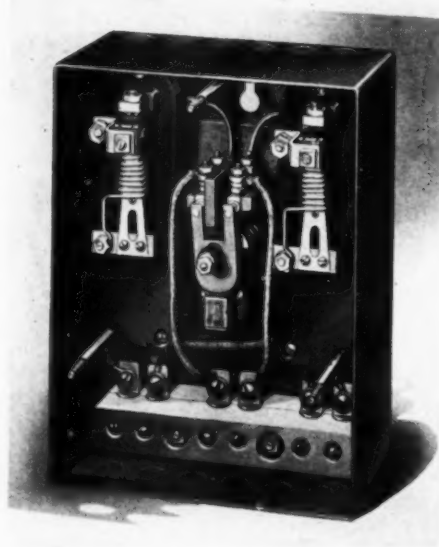
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SAFETY DEVICE THAT PROTECTS AGAINST OVERHEATING

Here is a thermostatic circuit breaking safety device designed to protect the circuit from overheating, due to excessive load.

The device is installed in the circuit supplying the range and water heater and is placed alongside the meter



A thermostatic circuit breaking safety device.

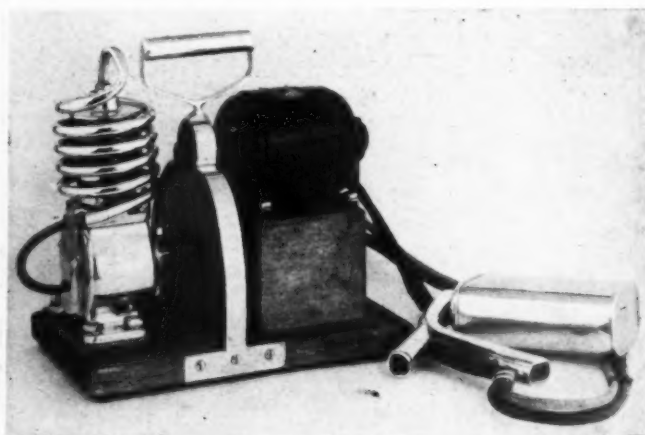
at the entrance switch, in the same manner as the usual watt-hour meter.

It automatically disconnects the water heater whenever the range load exceeds about one kilowatt.

This interconnecting switch is suitable for use only on alternating current circuits of twenty-five, fifty or sixty cycles, and is intended for use with any three wire 115/230 volt range with a connected load not greater than nine kilowatts.

AN ELECTRIC SPRAYER THAT IS PORTABLE

A new electric portable sprayer that will easily spread an insect poison has recently been introduced. This sprayer will kill at thirty feet, and is so made that no



liquid will drop from the mouth of the machine because the atomizer has been perfected to such a point that the liquid goes straight to its mark.

This machine is not for sale but is given away with the purchase of insect poison made by the company that manufactures the sprayer.

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*—withstand hard wear
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THE Eaton is essentially a hospital blanket manufactured upon definite specifications, the direct result of a long series of scientific tests under actual hospital conditions. EATON BLANKETS are standard equipment in hundreds of hospitals thruout the country. The mills where EATON BLANKETS are made have been operated continuously for 90 years.

EATON BLANKETS are made in mills out away from the crowded city where pure air circulating thru every department makes blankets more wholesome, more sanitary and more desirable for hospital use.

Any superintendent or purchasing agent for any hospital where EATON BLANKETS are not already in use is at liberty to send for samples of any style.

This trial order will be filled at our regular quantity price and may be returned for full credit.

Try an EATON BLANKET and be convinced.

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3001 Natural Gray	304 Lavender

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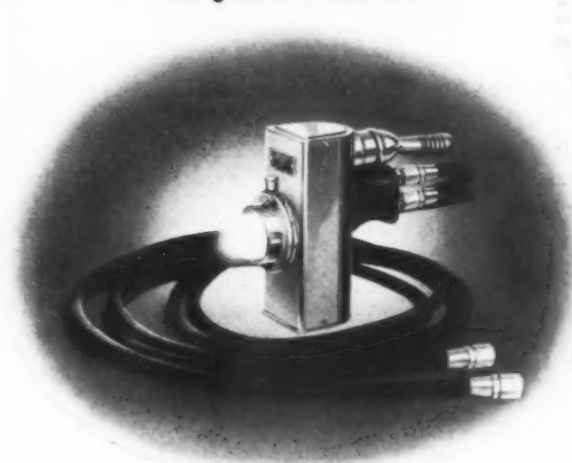
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WATER-COOLED MERCURY ARC QUARTZ LAMP

A perfection of technique—never possible before—can be easily developed with the new Burdick Ever-Clear Water-Cooled Quartz Lamp. In this highly scientific instrument precision reaches a new peak. You can measure your Ultraviolet dosage with an accuracy which merits your complete confidence.

No longer can the quartz window become clouded with a film deposited from the water stream—weakening the Ultraviolet emission to a steadily increasing extent. This great weakness of all Water-Cooled Lamps has been absolutely eliminated by Burdick engineers.

The Ever-Clear window is cooled by water that flows around its circumference instead of across its face. It can never become discolored. A cylindrical, parabolic reflector directs the maximum amount of Ultraviolet radiations through the Ever-Clear window. The intensity of your Ultraviolet radiation is greatly increased—perfectly controlled and permanently sustained.

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☐ Please send me, without charge, a monthly copy of your magazine, "Light Therapy."

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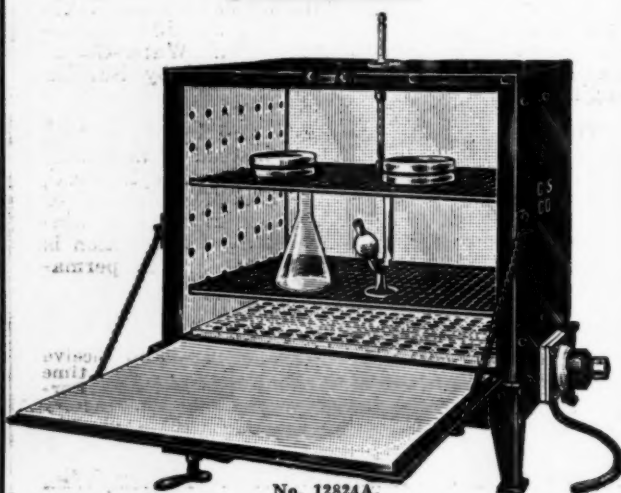
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Book Reviews and Current Hospital Literature

NUTRITION WORK WITH CHILDREN

By LYDIA J. ROBERTS, Assistant Professor of Home Economics, the University of Chicago.¹

This book is interesting because it is an outgrowth of outlines used by the author in her class work. She was therefore able to improve it from year to year. The book is especially valuable because the author has done a good deal of original work in the science of nutrition which is in direct contrast to a good many books on the market that are merely reviews of literature. There is also quite an extensive bibliography at the end of each chapter.

The type of the book is clear. The paragraphs, however, sometimes are rather lengthy and remind one of German medical publications where a paragraph sometimes starts at the top of one page and ends at the bottom of another page. In the preparation of a second edition of this book it may be advisable for the author to keep this point in mind and shorten some of the paragraphs.

MINERAL WATERS OF THE UNITED STATES AND AMERICAN SPAS

By WILLIAM EDWARD FITCH, M.D., Member, International Society of Medical Hydrology; American Medical Association; Medical Association of the Greater City of New York; Attending Physician, Vanderbilt Clinic, New York, College of Physicians and Surgeons, New York.²

Until recently medical hydrology has been associated almost entirely with European therapeutics, and people have gone to Europe for mineral water treatment when they could have received as good or, perhaps, better treatment at home had they and their physicians been informed of the extent and quality of our mineral water resources.

Although as early as 1831 a volume was written concerning our mineral water resources and several books have been produced since, these works are not of recent date and do not treat of the newer methods in mineral water analyses. The difficult task of presenting the history, location analysis, classification and therapeutics of the springs of this country has been left to Dr. Fitch, who has given us a thorough analysis of the situation.

It will probably surprise many readers to learn that the United States has 425 active spring areas, which are presented in this volume, and that we have more than one hundred spas, which are described and written about for the first time in Dr. Fitch's book.

In addition to the analyses and classification of the waters and their therapeutic properties, he has also treated of their latest application in medical hydrology. Because

¹ The University of Chicago Press, Chicago.

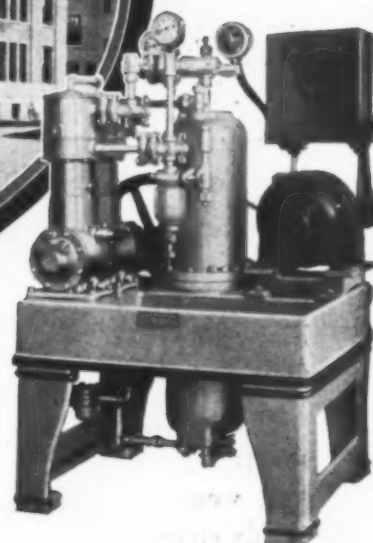
² Lea & Febiger, Philadelphia, and New York, 1927.

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Pepperell Manufacturing Company, Boston, Massachusetts. Mills at Biddeford, Maine, Lowell, Mass., Lindale, Ga., and Opelika, Ala. Sales Offices in New York, Boston, St. Louis, Chicago and San Francisco.

- of the importance of radium emanation in mineral waters, a chapter has been included on radio-activity of mineral waters. Also, for the first time in a work of this character, a chapter is devoted to outlining the dosage of mineral waters based on the degree of concentration of the predominating chemical constituents. The chapter on classification was written by Dr. E. E. Smith, president, Academy of Science, New York, to whom the book is dedicated.

As Dr. Fitch states in the preface, the book is an attempt to focus attention of the medical profession and people in general on our abundant mineral water resources, and it is hoped that Dr. Fitch's painstaking study and comprehensive presentation of the subject will go a long way in dispelling the ignorance concerning our natural hydrotherapeutic sources and that medical students may be taught to appreciate the value of hydriatics.

THE FIFTH AVENUE HOSPITAL CLINICS

Edited by JOSEPH H. FOBES, M. D., MILTON J. RAISBECK, M.D., D. S. D. JESSUP, M.D., CHARLES F. TENNEY, M.D.¹

This is the first of a series of volumes to appear under this title. It comprises a collection of papers presented at the semi-monthly evening staff meetings of the Fifth Avenue Hospital, New York, together with reprints of some articles published in connection with cases in the hospital. The articles are arranged chronologically in the order in which they were presented at the various staff meetings.

The book is illustrated with numerous charts and with several exterior and interior views of the hospital.

The publication annually of this series should be a stimulus to hospital betterment through example to medical staff men of other institutions.

WHAT'S BEST TO EAT

By S. HENNING BELFRAGE, M.D., With a Practical Supplement by LUCY H. YATES, M.C.A.²

Since nutrition and dietetics have not received as much attention in England as they have in this country, this book by Dr. Belfrage will no doubt be encouraging to his confreres and helpful to the laymen. The principles advocated are on the whole well known and commonly accepted in this country, although Dr. Belfrage emphasizes the importance of raw foods and fruits, "natural flavors" and similar food products to a greater extent than do some of our students of nutrition.

The terminology and many of the recipes in the supplement indicate British usage. The American edition has a foreword by E. V. McCollum.

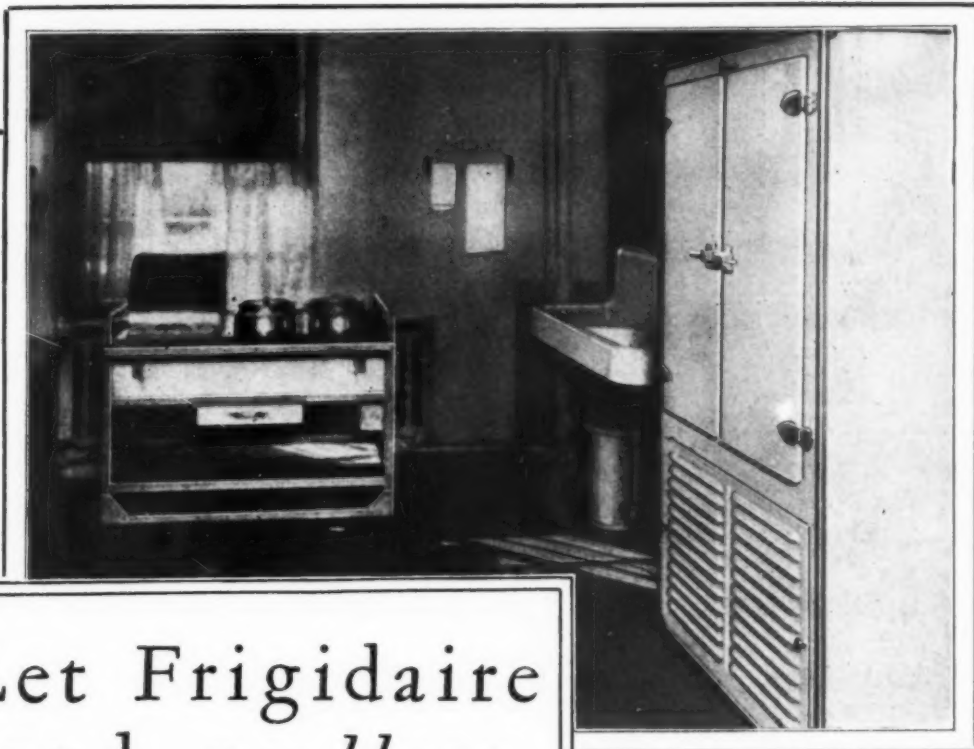
BOOKS RECEIVED

MODERN METHODS IN NURSING. By Georgiana J. Sanders, formerly Assistant Matron at Addenbrookes' Hospital, Cambridge, England; formerly Superintendent of Nurses at the Polyclinic Hospital, Philadelphia, and at the Massachusetts General Hospital, Boston. Fourth Edition, Thoroughly Revised. W. B. Saunders Company, Philadelphia and London, 1927. Price \$3 net.

THE MEDICAL DEPARTMENT OF THE ARMY. Its History, Activities and Organization. By James A. Tobey, Major, Sanitary Corps (Reserve), U. S. A. Johns Hopkins Press, Baltimore, 1927.

¹ Paul B. Hoeber, Inc., New York, 1927.

² William Wood & Co., New York.



Let Frigidaire end *needless* Expense in your Hospital

IN hospitals, as in hundreds of thousands of homes and business establishments, Frigidaire provides sanitary, dependable refrigeration at a cost much lower than ice. It eliminates losses due to spoiled foods. It permits the wholesale purchase of costly drugs and serums. It safeguards laboratory specimens and supplies. And it operates automatically—day and night, year after year—without ice and without attention.

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Frigidaire is made in a wide range of models with a corresponding range in price. There are complete, self-contained cabinet models. There are mechanical units in many styles and capacities for converting ice-boxes into Frigidaire. There are five models, of Frigidaire Water Coolers, and a Frigidaire Ice Maker that freezes practically twenty-two pounds

of ice cubes at one time. Whatever the individual needs of your hospital may be, you can easily find a model or models of Frigidaire that will exactly meet your requirements.

Write for specific information about Frigidaire for your hospital, and for details of the liberal General Motors payment plan.

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NEWS OF THE HOSPITALS

California

The new hospital at Sawtelle Soldiers' Home, Sawtelle, was formally opened on May 12. The building is six stories in height, is of steel and concrete construction, costing \$1,500,000. It is completely equipped with the most modern devices and has a capacity of 562 beds.

Indiana

The Robert W. Long Hospital, Indianapolis, has received a gift of more than \$2,000 for special equipment for the study and treatment of gastro-intestinal and rectal diseases. The gift has been placed at the disposal of Dr. Alois B. Graham, specialist in these diseases, by Arthur C. Newby, Indianapolis, a friend of Dr. Graham.

Plans were recently approved by the board of trustees of the University of Indiana for the erection of a \$500,000 structure for the Ball Nurses' Home and Training School, Indianapolis.

Maine

Construction is under way on a new \$450,000 hospital and nurses' home for Sanford, to be known as the Henrietta D. Goodall Hospital. It will contain about fifty beds and is being erected as a memorial to Mrs. Goodall by her husband and daughter.

Maryland

Dr. Winford H. Smith, superintendent, Johns Hopkins Hospital, Baltimore, has announced that changes and improvements in the kitchen and mess building of his institution are being made at a cost of approximately \$300,000. When completed the building will be six stories high and there will be accommodations for 500 people in the dining rooms.

The Johnston Memorial Children's Hospital and Nurses' Home, an addition to the Union Memorial Hospital, Baltimore, erected at a cost of \$600,000, provided in the will of Josiah Lee Johnston, will increase the capacity of the hospital to 227 beds. The new building contains two wards and seventy-eight beds, twenty of which will be free.

Massachusetts

The new six-story maternity unit of the Boston City Hospital, Boston, was recently opened. It provides accommodations for seventy-eight mothers and 123 babies. The building is of the ward type with glass cubicles for each patient. The nurseries are in series of ten cribs each.

A non-sectarian institution to be known as the People's Hospital, is to be erected at a cost of \$3,000,000 in Detroit. It will have 450 rooms with 120 beds for charity patients.

Minnesota

The new \$200,000 Webber Hospital, Duluth, was recently opened.

For Cleanliness in the Sickroom

Dirt, that most unwelcome hospital visitor, meets another rebuff in the new Sol-Lux hanger. Dust-collecting chains and wires have been replaced by a sightly semi-rigid type of suspension which is as easily cleaned as the globe of the Sol-Lux Luminaire.

An infrequent rub of the cleaner's cloth is all that is necessary to remove all dust from the entire unit. For the globe needs no cleaning within. No dust, no insect, no outside dirt whatever, can get past the air-tight ring between husk and glass.

There's an interesting story concerning Sol-Lux and the features which produce bright light without glare—a most convincing testimonial to its worth as hospital equipment. Write for descriptive circular.

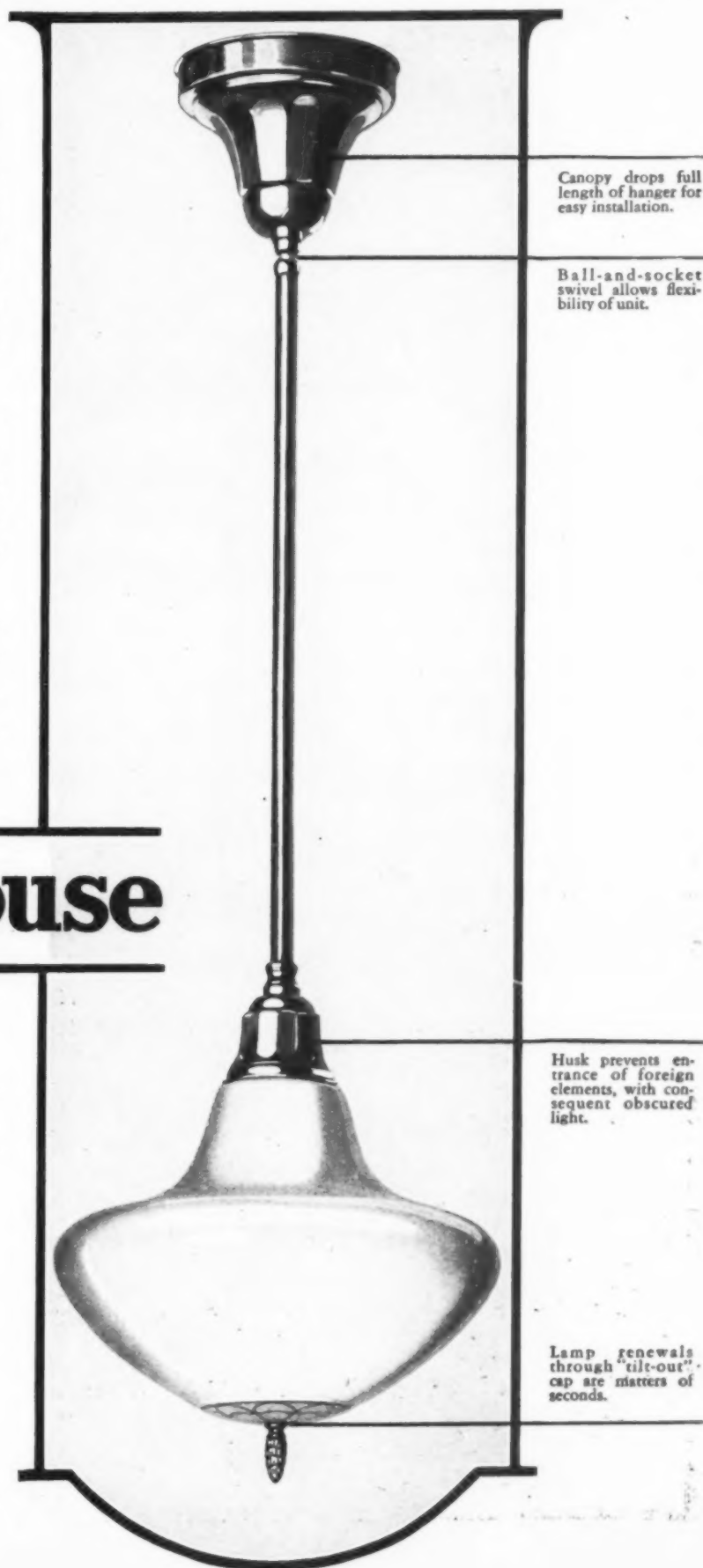
Westinghouse

WESTINGHOUSE ELECTRIC & MANUFACTURING COMPANY

Merchandising Department

SOUTH BEND WORKS

SOUTH BEND, INDIANA

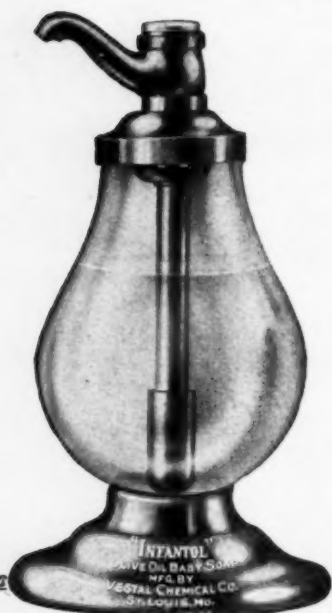


Canopy drops full length of hanger for easy installation.

Ball-and-socket swivel allows flexibility of unit.

Husk prevents entrance of foreign elements, with consequent obscured light.

Lamp renewals through "tilt-out" cap are matters of seconds.



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The Olive Oil Baby Soap

**ECONOMICAL EFFICIENT
SANITARY**

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VESTAL CHEMICAL CO., St. Louis, U.S.A.



A three-story addition to the Union Hospital, New Ulm, is being constructed at an estimated cost of \$65,000. The building will add thirty-six beds to the hospital's capacity and completion is expected before fall.

Missouri

With a sum of \$230,000 provided in the will of Nathan Schloss, as a foundation, a drive will be conducted to raise one million dollars for the erection of the Jewish Memorial Hospital for Kansas City.

Nevada

Announcement has been made of the completion of the new \$10,000 hospital on the Indian Reservation at Pyramid Lake.

New Jersey

A campaign for \$850,000 for a new Presbyterian Hospital for Newark, has been oversubscribed, \$923,000 having been secured through the drive. The new structure will have a capacity of more than 300.

West Jersey Homeopathic Hospital, Camden, recently opened the Marion Childs Hospital for Children which marks the completion of two units donated by S. Canning Childs, adding ninety-four beds to the capacity of the institution. The Children's Hospital contains private rooms and cubicles, operating room, roof garden and play rooms and has been constructed at a cost of \$200,000 with an additional \$25,000 for equipment. The building is named for Mrs. Bayard Kraft, daughter of S. Canning Childs, the donor.

New York

The medical library, equipment and the bulk of the tangible property of the late Dr. Henry W. Frauenthal, founder of the Hospital for Joint Diseases, New York, have been bequeathed to the hospital. The balance of the estate is to be held in trust for his brothers and sisters and upon their deaths is to be turned over to the hospital for the laboratory endowment fund.

A new sixty-bed building for the Brooklyn Hebrew Maternity Hospital, Brooklyn, is to be built this summer. Upon completion of the new hospital the old building will be converted into a training school and home for nurses.

A 200-bed addition to St. Vincent's Hospital, Staten Island, will be built during the coming year to relieve the crowding of the present building and other hospitals on the Island.

Victory Memorial Hospital, Brooklyn, was officially opened recently. Construction of this hospital began in 1917 but it was not completed until this year because of lack of funds.

North Carolina

A campaign is being conducted by the Baptist women of North Carolina for the funds to erect a nurses' home for the Baptist Hospital, Winston-Salem, to be known as the Blanche Burrus Nurses' Home.

North Dakota

The site has been purchased for the \$250,000 hospital which is to be erected in Valley City by the Sisters of Mercy.

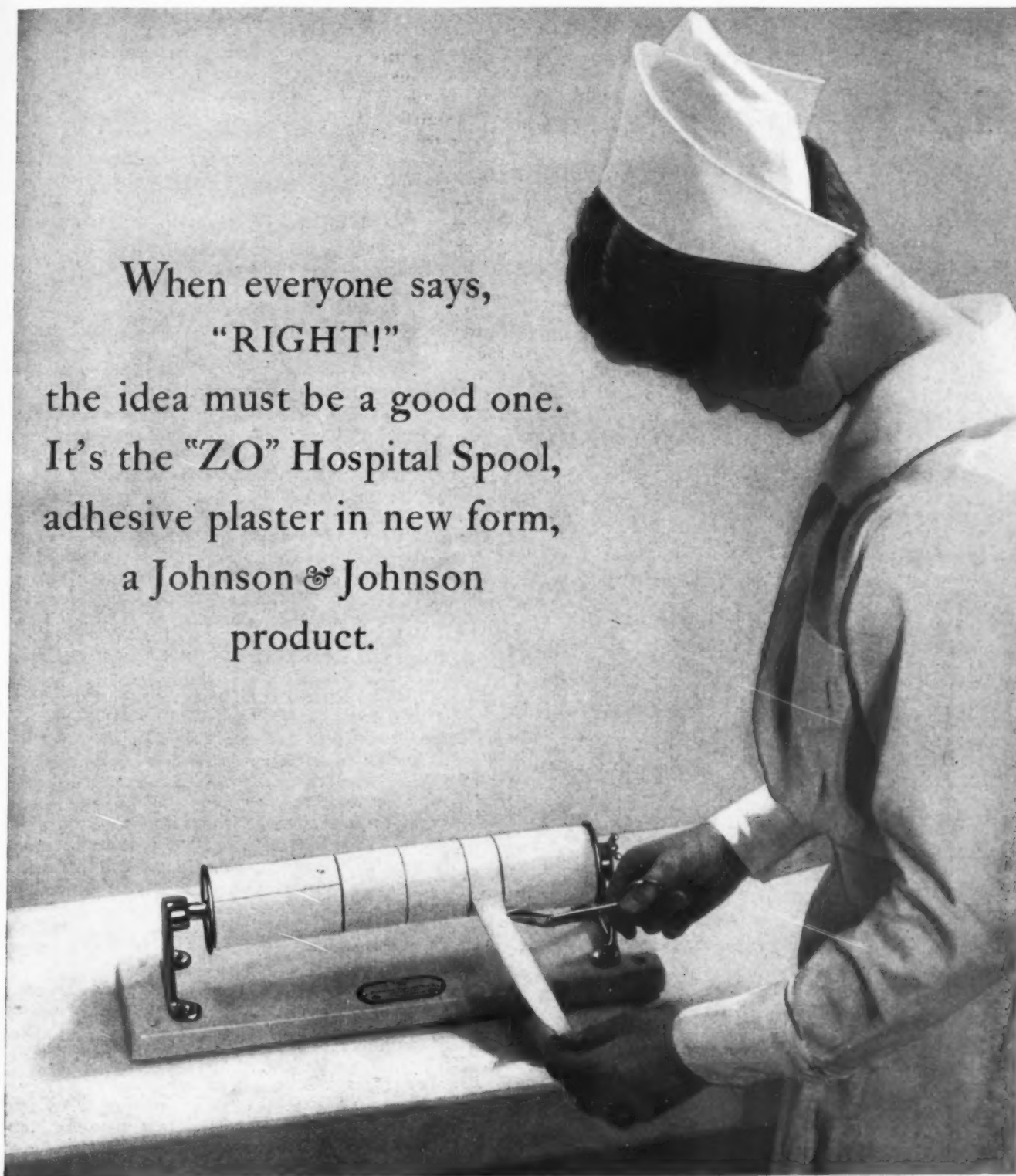
Oregon

The Dalles has been chosen as the location for the new Eastern Oregon Tuberculosis Sanatorium. The first step in the work has been the grading of the highway leading to the hospital site.

Sixty patients can be accommodated in the Emanuel Hospital, Portland, which was recently remodeled into a maternity hospital.

When everyone says,
"RIGHT!"

the idea must be a good one.
It's the "ZO" Hospital Spool,
adhesive plaster in new form,
a Johnson & Johnson
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NEW BRUNSWICK, N.J., U.S.A.



Leading Hospitals Vote "Yes"

THE LEADING HOSPITALS in every section of the country have enthusiastically endorsed the new "ZO" Hospital Spool.

Its usefulness grows daily, on dressing carts, in first-aid rooms, dressing rooms, out-patient clinics and even operating rooms. With all its convenience, the plaster remains the same in price.

This is one hospital specialty you can't afford to overlook. We sincerely urge you to write us promptly for additional information.

For data on all equipment and supplies consult the YEAR BOOK

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IT'S one thing to relieve constipation—quite another to prevent its recurrence. ALL-BRAN does both. Eaten regularly, it performs a double service—thereby making for lasting relief.

Only an ALL-BRAN product could do the work of Kellogg's ALL-BRAN. Doctors know they can rely upon it to accomplish definite results, because it is 100% bran. Results a part-bran product could hardly hope to achieve.

When bran is indicated, recommend ALL-BRAN. It's a prescription patients enjoy. Delicious served as a breakfast cereal—or it may be used in many kinds of cooking.

Made by Kellogg in Battle Creek. Sold by all grocers. Served everywhere.

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Pennsylvania

A new institute for mental and nervous diseases, a new maternity department and nurses' training school and home is the building program of the Pennsylvania Hospital, Philadelphia, in its campaign for \$3,500,000.

Five thousand beds will be added to the Veterans' Hospital, Philadelphia, through the appropriation bill for \$16,000,000, which includes \$3,500,000 for this purpose.

The University of Pennsylvania Hospital, Philadelphia, has received \$5,000 from the estate of Mrs. Adelaide V. Brunner, Philadelphia.

Six beds are to be established in Lankenau Hospital, Philadelphia, through the \$3,500 gift from the estate of Mary Luders. From the same source the Children's Homeopathic Hospital received \$5,000 and Kensington Hospital \$15,000.

A \$4,000,000 building campaign by the Federation of Jewish Charities was started when ground was broken recently for a \$750,000 building in Philadelphia.

The recent dedication of the new wing for the nurses' building marked the celebration of the seventy-fifth anniversary of the Episcopal Hospital, Philadelphia.

A \$250,000 building is to be constructed for the Sewickley Valley Hospital, Sewickley.

Virginia

The Memorial Hospital, Lynchburg, received a bequest of \$500,000 for the establishment and maintenance of a children's and maternity hospital, in the will of the late Mrs. Bertha Virginia Guggenheimer.

Washington

Seattle has announced a million dollar hospital construction program, to include a \$400,000 nurses' home for the Providence Hospital and a new hospital structure to cost \$600,000 to be erected by Minor Hospital. The new Minor Hospital building will be nine stories in height and have accommodations for about 235 beds.

The new three-story \$200,000 Walla Walla General Hospital, Walla Walla, was recently opened. This structure replaces the wooden building destroyed by fire some time ago.

Canada

An extensive building program for the Toronto General Hospital, Toronto, has been announced by the board of governors. It will include a pathology building, nurses' home and a pavilion for private patients, increasing the bed capacity by 200.

Foreign

The Dairen Hospital, Manchuria, considered the largest hospital ever constructed in the Orient, recently celebrated its completion and opening. At the same time the Manchurian central medical laboratory was completed and formally opened, invitations being issued to 400 persons in China and Japan.

Reconstruction of hospitals and asylums destroyed by the hurricane in Cuba last fall has been begun. About 375,000 pesos has been appropriated by the Cuban government for this work.

The general hospital at Port-au-Prince, Haiti, has recently added new wards accommodating seventy-two additional patients and a new wing is now under construction.

A sum of \$650,000 toward the \$1,500,000 buildings to be constructed for the faculty of medicine at Sao Paulo, Latin America, will be given by the Rockefeller Foundation, the state government agreeing to construct hospitals to be operated in connection with the school of medicine.



Coolidge & Statluek, Architects

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IS EQUIPPED WITH
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HEAT CONTROL

Ask the officials of Boston Lying-in Hospital regarding the accuracy, reliability and results of Johnson Heat Control, and the valuable services obtained. Thus determine the high quality of Johnson Heat Control—the benefits you will derive from having it in your hospital, the losses you will incur by omitting it: including the 25 to 40 per cent fuel saving possible.

Make inquiry of any of these hospitals; and have us furnish you with complete details of installation, etc.

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BRANCHES IN ALL PRINCIPAL CITIES

THE ALL METAL
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Other Hospitals Johnson Equipped

General Hospital,	-	-	Mt. Pleasant, Iowa
St. Joseph Hospital,	-	-	Mason City, Iowa
Masonic Orphans Home,	-	-	Fort Worth, Texas
Eastern Oklahoma Hospital,	-	-	Vinita, Oklahoma
Finlay Hospital,	-	-	Dubuque, Iowa
Tennessee Coal & Iron Employees Hospital,	-	-	Fairfield, Ala.
St. Luke's Hospital,	-	-	Chicago
Mercy Hospital,	-	-	Pittsburg, Pa.
Christian Church Hospital,	-	-	Kansas City, Mo.
Vassar Brothers Hospital,	-	-	Poughkeepsie, Pa.
Northern Pacific Beneficial Association Hospitals	-	-	St. Paul, Minn. - Missoula, Mont.
St. Elizabeth Hospital,	-	-	Boston



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THE Stanley Coffee Server doubly safeguards the comfort of its users.

Of all-metal construction, lined with procelain enamel, *it can't break!* And it keeps contents hot or cold all day long—or all night.

There is a Stanley to fit every need—Coffee Server, Pitcher, Carafe, Bottle, Jug. Each extremely handsome in design and obtainable in a variety of color combinations.

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THERMAL CONTAINERS
“They will not break”

Trade News and Publications

Toilet Seats.—San Duro Corporation of Illinois, Chicago, has issued a leaflet containing prices and information regarding the San-Duro bakelite toilet seat, which is moulded in one piece, is non-porous and acid resisting.

Water Tube Boilers.—An interesting broadside has been received from the Hanna Company, Chicago. Its water tube boilers are designed to burn oil, coal and garbage at one time, if desired. The fire produced by the burning of the garbage insures a constant supply of hot water daily, by adding a small amount of fuel. The boilers can also be equipped to burn coal without the oil burner. Excellent photographs illustrate the exterior mechanism, and there is a phantom view of the interior which shows how the flame is carried up to the water tubes.

Metal Mouldings.—The Metal Forming Corporation, Elkhart, Ind., is sending out a catalog illustrating the many kinds of metal tubings and mouldings which it manufactures. In addition to the illustrations, there are tables of gauges and weights of various metals, tubings and bars. Mouldings may be formed from many different metals in innumerable designs, and the company is prepared to make quotations on such work on receipt of blueprints.

Structural Insulation.—From the Mason Fibre Company, Chicago, has been received a booklet giving specification details for the use of Masonite, a manufactured insulation lumber composed entirely of wood fibre. The specifications furnished indicate its use as sheathing, plaster base, roof insulation and sound deadening. The results of tests for absorption, insulation, strength and nail holding are given, and an interesting insert is a chart of heat loss and condensation planned to aid in the quick calculation of two factors commonly affected by the use of insulating materials.

Power Plant Equipment.—Engberg's Electrical & Mechanical Works, St. Joseph, Mich., has issued a circular illustrated with photographs of representative installations of engines, generating sets, generators and motors. Engines have been installed in oil refining plants, paper mills, sewage disposal plants, machine shops, canning factories, colleges, hospitals and sanatoriums, as well as in many other diversified industries. They may be used for driving stokers, fans, blowers, compressors, pumps, mixers, driers, agitators, generators and other auxiliary equipment, and the generators may be combined with these same engines to form the generating sets. The legends accompanying the photographs are particularly interesting, and contain much information that should prove valuable to power plant engineers.

Screens.—The Johnson Metal Products Co., Erie, Pa., has mailed out an attractive booklet on screens and the manner in which they should be adjusted. The booklet is a useful addition to the supply files.

Foodstuffs.—The S. S. Pierce Company, Boston, has issued its spring and summer price list and is mailing it to hospitals in every part of the United States.

Nobody Questions a Photograph

Because of the circumstances under which clinical photographs are made, because no personality enters into their production, there is an undisputable honesty about them. They are, in fact, scientific records of the conditions pictured. Such scientific recording is a justifiable part of a hospital's activity.

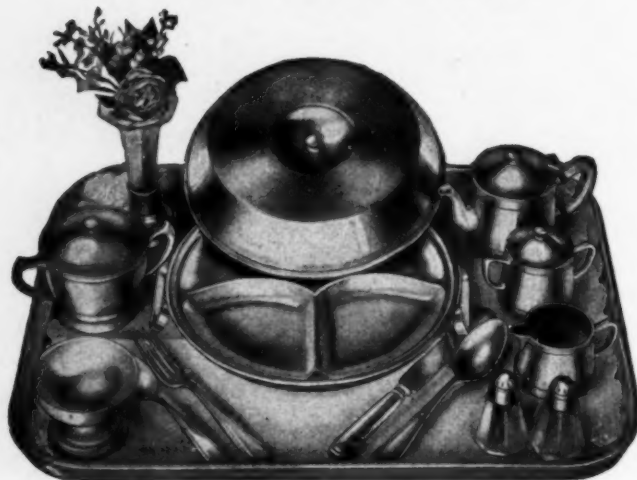
No hospital is completely equipped which lacks adequate photographic equipment.

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THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Plate Flatware.

THORNER BROTHERS

*Importers and Manufacturers of
Hospital and Surgical Supplies*

386-390 Second Avenue
NEW YORK CITY

Washing Machines.—Henrici Laundry Machinery Co., Boston, has issued a comprehensive catalog of its complete line of washers. The catalog is well illustrated and contains descriptions of the different models, as well as detailed information on the mechanism of the various parts. General specifications are given for the installation of the machines and a list of the hospitals and institutions using the washers is also included.

Oil Burners.—In an attractive booklet recently sent out by Hardinge Brothers Inc., Chicago, the history of the Hardinge Fuel Oil Burner is interestingly told, and there is an excellent schematic photograph of its construction details. Other photographs show the various types of buildings in which Hardinge burners have been installed, and the engineering tests made with this type of burner should prove valuable to anyone interested in oil burning equipment.

Valves and Faucets.—Catalog M has just been received from the Bashlin Company, Warren, Pa., in which the advantages of its valves are set forth. The booklet is profusely illustrated, and the faucets and valves are minutely described and the prices listed.

Steam, Vapor and Hot Water Heaters.—Spencer Heater Company, Williamsport, Pa., has sent out an interesting booklet, "The Business of Buying a Heating System," and its Catalog 21. The catalog contains many illustrations of its various types of heaters, their sectional parts, and a number of dimension sheets. Under the illustration of each heater, ratings and dimensions are given, and there is also much useful information on the construction, cleaning and tending of the heaters. The booklet deals with such questions as confront the person who is considering the installation of a heating system. There is the type of system to be considered, together with the important question of cost. Many of the facts set forth are taken from correspondence with persons all over the country who own and operate heating systems, and quotations have been made from articles, tables and data by a number of authorities. Accompanying these booklets is a postcard which may be used to request more complete information.

Accounting System for Hospitals.—From Con. P. Curran Printing Co., St. Louis, Mo., comes the announcement of an accounting system planned especially for hospitals having 100 beds or less. The system is based on an exhaustive study of accounting methods now in use, and will be sufficiently comprehensive to supply all information necessary to efficient business management. The system will be semi-automatic, and will combine in a single loose-leaf book practically all the forms used in the general accounting. Full details may be secured by writing to the company.

Window Glass.—The Vita Glass Company, New York, has mailed to the hospitals of the country a new booklet describing this product and telling of the accomplishments that have already been recorded. The ability of this glass to transmit ultraviolet rays is also explained.

Chemicals.—The Mallinckrodt Chemical Works, St. Louis, Mo., have issued their May price list. An important announcement is contained in the folder inasmuch as hereafter one-quarter pound packages will be priced per package rather than at the pound rate as heretofore.

Blankets.—Horner Brothers Woolen Mills, Eaton Rapids, Mich., have issued a folder containing three samples of the material used in making their Eskimo Suits. A full description of these suits, and prices for sizes and quality are given. The Eaton Eskimo Porch Robe is also described and priced.



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THE LIGHTNING CLEANSER

WHEREVER FLOORS GET UNUSUAL WEAR—in hospitals, banking rooms, office buildings, libraries or retail sales rooms—MIDLAND TILEOLEUM will preserve their beauty and lessen the cost of upkeep. Compounded especially for the cleaning of tile, marble and terrazzo floors and tile and marble walls, it does the work thoroughly and with little effort.

MIDLAND TILEOLEUM does not merely remove the surface dirt—it seeks out the tiny pores of the tile and loosens the grime and grit no matter how deeply imbedded. Floors that have not had a real cleaning in years yield to MIDLAND TILEOLEUM and soon appear like new. If you have the task of keeping tile in good condition try a drum of this wonder cleanser. The first trial will convince you.

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BEFORE you purchase uniforms for your next class of pupil nurses, let us quote you on them. A large part of the capacity of our garment factory is devoted to making pupil nurses' uniforms, aprons, and caps. We use materials that insure satisfactory wear, and give them a double shrinking. Our uniforms are cut to fit well and look well, and are carefully made by capable operators. Perhaps we'll save you a little money on your uniforms. We'd like the opportunity of quoting you at least.

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Manufacturers, Importers,
and Distributors of a complete line of hospital supplies and equipment.

Bed for Premature Babies.—A crib bed for premature or weak babies is illustrated and described in a leaflet just received from J. A. Deknatel & Sons, Inc., Queens Village, Long Island, N. Y. The crib is adjustable, well protected and easily accessible, with uniformly warmed and suitably moistened ventilated air. The baby can be fed, bathed and treated without being removed from the bed. It is practical and entirely possible to care for premature infants in these cribs in the regular nursery, an important factor in hospitals where space does not allow the establishment of a separate room for the care of these infants. The crib is equipped with rubber-tired wheels that make moving it about an easy task.

Ventilating Equipment.—Midwest Air Filters, Inc., Bradford, Pa., has just issued an interesting treatise on ventilating problems encountered and overcome by the New York Public Library. The booklet is concise and well illustrated, and the experiments made are illuminating, especially as regards the reactions of various types of people to the subject of ventilation. Bulletin MH-1 has also been received from this concern, and it contains excellent diagrams of air filter installations.

Visible Record System.—The Acme Card System Company, Chicago, Ill., has issued a colorful broadside descriptive of its system of visible records. With this system it is possible to see at a glance all the pertinent facts regarding any subject indexed. The advantages of the system are explained in detail, and a return mailing card is enclosed which may be used to obtain prices and further information.

Copper Insect Screen Cloth.—Bulletin No. 3880 has just been mailed by the New Jersey Wire Cloth Company, Trenton, N. J. While the information contained in this book is intended primarily to increase the use of copper insect screen cloth, it contains other facts on various subjects that should prove valuable. Some of the questions discussed concern the use of copper screening, the proper size of mesh, cost and quality, finish, other uses for Jersey copper insect screen cloth, corrosion of metals, insects that cause disease and discomfort, suggestions from the United States Public Health Service, and varnish and paint suggestions. There is also an illustrated insert showing each step in making insect screens, which is reprinted from *Popular Science Monthly* through the courtesy of the publishers. Included with the booklet are attractive samples of screening, and a catalog folder of various other products made by this company, who also have ready for mailing a booklet entitled "A Matter of Health and Comfort," No. 26, which they will be glad to send on request.

Dumb-Waiters and Elevators.—The Sedgwick Machine Works, New York, have sent out a new catalog called Catalogue P in which are described many types of elevators and dumb-waiters. There are many illustrations, sectional drawings and specifications, besides descriptions of the various apparatus that this company is marketing.

Steel Equipment.—All-Steel Equip Company, Aurora, Ill., has published a booklet on Utility Steel Equipment for hospitals and institutions. Many new ideas in cabinets and lockers as well as storage space for linen, blankets and other uses of steel equipment are described both by text and illustration. The booklet should be in the files of hospital superintendents.

Bedside Tables.—The Max Woche and Son Company, Cincinnati, Ohio, has issued a folder describing its line of bedside tables. The folder is in colors and shows several types of tables that have proved to be popular in hospitals.